We Care Chiropractic Center
Helping to improve your quality of life since 1985!

Lumbar Pain Questionaire

#:_____
Name:_____ Today's Date: _____

1 Date of onset: _____

2 Location of pain: ( ) Lumbar ( ) Lumbosacral ( ) Sacro-Illiac

Left Middle Right

( ) Worse on Left ( ) Worse on Right

Pain Levels: (10 being worst)
0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

3 Since it started the pain has been:
( ) Constant ( ) Persistant
( ) Intermittant (comes and goes) ( ) Progressive (slowly getting worse)

4 Type of pain:
( ) Dull ache ( ) Burning ( ) Throbbing ( ) Sharp
( ) Deep ache ( ) Shooting ( ) Numbness ( ) Tingling
( ) Nauseating ( ) Other: _____

5 Radiating Pain: Yes / No
A ( ) Bilaterally ( ) Right Only ( ) Left Only
B ( ) Mild ( ) Moderate ( ) Severe
C ( ) Tingling ( ) Numbing ( ) Aching
( ) Shooting ( ) Burning ( ) Other: _____
D Where does it radiate to?
( ) Buttock ( ) Hip ( ) Groin
( ) Back Thigh ( ) Front Thigh ( ) Side of Thigh
( ) To Knee ( ) Side of Lower Leg ( ) Calf
( ) Into Foot
E Does it make you limp? Yes / No
F Do you drag your foot? Yes / No

6 Do you get an increase in pain with:
( ) Coughing ( ) Sneezing ( ) Straining with a bowel movement

7 Do you have problems with the following?
( ) Bowel control
( ) Bladder Control

8 When is the pain worst?
( ) Morning ( ) Afternoon ( ) Evening

9 Do you have problems going up or down stairs? Yes / No

Doctor's Notes: _____
_____