BACK ASSESSMENT FORM

Date _____

File No. _____

Name _____ Occupation _____

Work Activities are mostly: Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Varied ☐

Other *(Please describe)* _____

How do you rate your work?: Physically Heavy ☐ Moderate ☐ Light ☐ Other ☐

Is this the first time you have had a back problem? Yes ☐ No ☐

How did you hurt your back this time? Lifting ☐ Fell ☐ Just came on ☐

Other *(Please describe)* _____

Are you off work for this? Yes ☐ No ☐ If off work, how long have you been off? _____

Have you had any previous attacks of backache in the past 5 years? Yes ☐ No ☐

If yes, how many previous attacks? One other ☐ Several ☐ Frequent attacks ☐ Don't remember ☐

Have you had to change jobs because of your back? Yes ☐ No ☐ No, but would like to ☐

What Treatment are you having for this problem? Bed Rest ☐ Pain Pills ☐ Physical Therapy ☐

Chiropractic ☐ Surgery ☐ Other *(Describe)* _____

What treatment have you had for past problems? Bed Rest ☐ Pain Pills ☐ Physical Therapy ☐ Chiropractic ☐

Surgery ☐ Corset ☐ No Treatment ☐ Not applicable ☐ Other _____

What are your symptoms now? Back Pain only ☐ Leg Pain only ☐ Back & Leg Pain ☐

Numbness or numb feeling ☐ Pins & Needles ☐ Other symptoms *(Describe)* _____

Is your pain constant & never changes ☐ Constant but varies in amount ☐ Comes & Goes ☐

What medication are you taking? _____

Have you had treatment or are you having treatment for a stomach ulcer? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

If Yes, how many a day _____

Do you engage in any exercise or sports activities? Yes ☐ No ☐

If yes, what? _____

_____

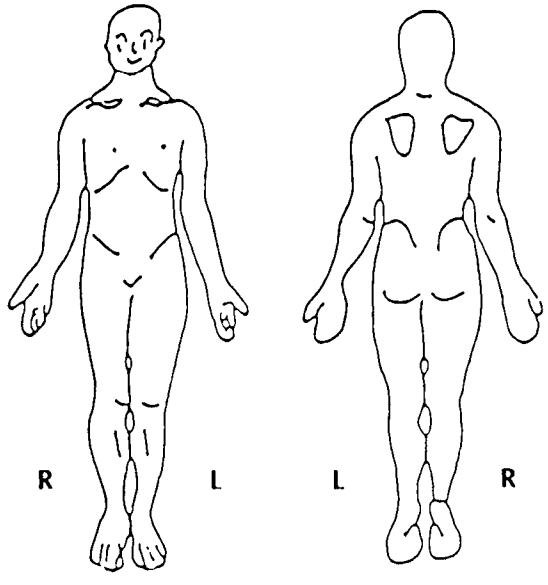
How often? _____

_____

What kind of bed do you have? _____

Firm ☐ Soft ☐ Waterbed ☐

Other _____



MARK ON THE DRAWING WHERE YOUR PAIN IS