

LOW BACK PAIN MEDICAL SCREENING QUESTIONNAIRE

NAME: _____

DATE: _____

Medical Record #: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you recently had a major trauma, such as a vehicle accident or a fall from a height? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had a medical practitioner tell you that you have osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your pain ease when you rest in a comfortable position? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you recently had a fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you recently lost weight even though you have <i>not</i> been attempting to eat less or exercise more? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you recently taken antibiotics or other medicines for an infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you currently taking steroids or have you been on prolonged steroid therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been diagnosed with an immunosuppressive disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you noticed a <i>recent</i> onset of difficulty with retaining your urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you noticed a <i>recent</i> need to urinate more frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you noticed a recent onset of numbness in the area of your bottom where you would sit on a bicycle seat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you recently noticed your legs becoming weak while walking or climbing stairs? | <input type="checkbox"/> | <input type="checkbox"/> |

Adapted from Bigos et al. AHCPR Clinical Practice Guideline. No. 95-0642