



Patient Name: _____

Date of Birth: _____

Low Back Intake Survey

1. In general, would you say your health is:

Excellent Very Good Good Fair Poor

2. How much difficulty do you have bending over?

Unable to perform A lot Some A little None

3. How much difficulty do you have lifting/carrying items that weigh >20 pounds?

Unable to perform A lot Some A little None

4. How much difficulty do you have standing for >30 minutes?

Unable to perform A lot Some A little None

5. How much difficulty do you have walking for >30 minutes?

Unable to perform A lot Some A little None

6. How much difficulty do you have sitting for >1 hour?

Unable to perform A lot Some A little None

7. Please indicate your pain range within the last week giving a score for the lowest and highest on the scale below.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever