

AppliedOrtho Physical Therapy LLC

Low Back Pain Medical Screening Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you have any ongoing disease process such as Arthritis, Osteoporosis, or Cancer?  
 Yes  No  
If yes, Please specify: \_\_\_\_\_
2. Have you had a recent Physical Examination including X rays and Laboratory test?  
 Yes  No
3. Have you recently loss more than 10 pounds?  
 Yes  No
4. If you answered Yes to the above question, was this due to dieting?  
 Yes  No
5. Are you experiencing any bowel irregularities?  
 Yes  No
6. Are you experiencing any abdominal pain or problems?  
 Yes  No
7. Are you experiencing any rectal bleeding?  
 Yes  No
8. Are you experiencing any bladder irregularities?  
 Yes  No
9. Are you experiencing any menstrual irregularities?  
 Yes  No
10. If you answered yes to any question between numbers 5 and 9, are you currently under the care of a physician for these problems?  
 Yes  No
11. Do you experience any weakness in your legs during walking?  
 Yes  No
12. Do you have any pulsating pain in your back?  
 Yes  No
13. Do you get pain in your legs that is caused by walking and relieved by rest?  
 Yes  No
14. Do your feet feel cold or more painful during cold weather?  
 Yes  No
15. Do you get pain in the tip of your tailbone?  
 Yes  No
16. Does your entire leg ever become painful (front, sides, back) at the same time?  
 Yes  No
17. Does your entire leg ever become numb (front, sides, back) at the same time?  
 Yes  No

18. Does your leg ever give way?  
 Yes  No
19. Have you had periods of time in the past year or during this episode when you have had very little pain?  
 Yes  No
20. Have you ever had to report to an emergency room because of back pain?  
 Yes  No
21. Have you had any treatment for your problem that has helped?  
 Yes  No
22. Has all treatment for your back made you worse?  
 Yes  No
23. Do you have any numbness or tingling in your buttocks or genital region?  
 Yes  No