gophysicaltherapy WHAT MOVES YOU

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

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