Name:___________________________________ DOB:__________________

BlueChoice® HealthPlan
GREAT EXPECTATIONS®† *Back Care Questionnaire*

Please complete the following survey and take it with you to discuss at your next physician's office visit.

1. Where in your back do you feel pain?

Neck Mid or Upper Back Low Back

2. Approximately how long have you experienced back pain symptoms (i.e., muscle aches, shooting/stabbing pain, reduced flexibility, reduced range of motion, or an inability to stand straight)?

Less than 6 weeks 6-12 weeks More than 12 weeks

3. How would you rate your pain on a scale from 1 to 10, with 1 being mild pain and 10 being unbearable pain? __________

4. Does your back pain extend (radiate) around the side of your chest or abdomen?

Yes No

5. List any treatment you have used, such as rest, ice/heat packs, painkillers, anti-inflammatory medicine, or physical therapy in the past four to six weeks.

6. What type of health care professionals have you seen for diagnosis and treatment of your neck or back pain?

7. How effective is your current back pain treatment?

Excellent Good Fair Poor

8. Other Comments:

Sources
American Academy of Family Physicians
National Institute of Neurological Disorders and Stroke

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