

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (REVISED-OSWESTRY)

Patient Name: _____

Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

<p>SECTION 1 – PAIN INTENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is very severe. <input type="checkbox"/> The pain is severe and does not vary much. <p>SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes me pain. <input type="checkbox"/> Washing and dressing increase the pain but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increase the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain I do any washing and dressing without help. <p>SECTION 3 – LIFTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights of the floor, but I manage if they are conveniently positioned (e.g. on a table). <input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights at the most. <p>SECTION 4 -WALKING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain on walking. <input type="checkbox"/> I have some pain on walking but it does not increase with distance. <input type="checkbox"/> I cannot walk more than one mile without increasing pain. <input type="checkbox"/> I cannot walk more than ½ mile without increasing pain. <input type="checkbox"/> I cannot walk more than ¼ mile without increasing pain. <input type="checkbox"/> I cannot walk at all without increasing pain. <p>SECTION 5 – SITTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can only sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than half one. <input type="checkbox"/> Pain prevents me from sitting more than 10 minutes. <input type="checkbox"/> I avoid sitting because it increases pain straight away. 	<p>SECTION 6 – STANDING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain on standing but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 10 minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases the pain straight away. <p>SECTION 7 – SLEEPING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain my normal night’s sleep is reduced by less than ¼. <input type="checkbox"/> Because of pain my normal night’s sleep is reduced by less than ½. <input type="checkbox"/> Because of pain my normal night’s sleep is reduced by less than 3/4. <input type="checkbox"/> Pain prevents me from sleeping at all. <p>SECTION 8 – SOCIAL LIFE</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain. <p>SECTION 9 – TRAVELING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I get some pain while traveling but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while traveling but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down. <p>SECTION 10 – CHANGING DEGREE OF PAIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.
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Pain Scale: Rate the Severity of your pain by checking one box on the following scale

1	2	3	4	5	6	7	8	9	10
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NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Patient Name: _____

Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

<p>SECTION 1 – PAIN INTENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. <p>SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self care. <input type="checkbox"/> I do not get dressed; I wash with difficulty and stay in bed. <p>SECTION 3 – LIFTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. <p>SECTION 4 - READING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want with moderate pain in my neck. <input type="checkbox"/> I can hardly read at all because of severe pain in my neck. <input type="checkbox"/> I cannot read at all. <p>SECTION 5 – HEADACHES</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time. 	<p>SECTION 6 – CONCENTRATION</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can concentrate fully when I want to with no difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all. <p>SECTION 7 – WORK</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can only do my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I can't do any work at all. <p>SECTION 8 – DRIVING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my care as long as I want with moderate pain in my neck. <input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> I can't drive my car at all. <p>SECTION 9 - SLEEPING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr. sleepless) <input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs. sleepless) <input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs. sleepless) <input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs. sleepless) <input type="checkbox"/> My sleep is completely disturbed (5-7 hrs. sleepless) <p>SECTION 10 - RECREATION</p> <ul style="list-style-type: none"> <input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck. <input type="checkbox"/> I can't do any recreation activities at all.
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Pain Scale: Rate the Severity of your pain by checking one box on the following scale

1	2	3	4	5	6	7	8	9	10
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UPDATED SUBJECTIVE COMPLAINTS

Name: _____ Date: _____ File #: _____
 Address: _____ Phone: Home: _____ Cell: _____
 City/ST/Zip: _____ INDICATE ANY CHANGE IN INSURANCE STATUS:
 INDICATE IF THERE HAS BEEN AN EMPLOYMENT CHANGE: Insurance Company: _____
 Employer's Name: _____ Address: _____
 Address: _____ City/ST/Zip: _____
 City/ST/Zip: _____ Name of Insured (if other than patient): _____

PRESENT COMPLAINTS

___ HEADACHE ___ NECK ___ Pain ___ Spasm ___ Tender ___ Sore ___ Ache ___ Shooting ___ Weak
 ___ Numb Other: _____. How has your condition changed since your last exam? ___ Less Pain
 ___ Same Pain ___ More Pain ___ Increased Motion ___ Same Motion ___ Decreased Motion Other: _____.

___ MIDBACK ___ SHOULDERS ___ ARMS ___ HANDS ___ Pain ___ Spasm ___ Tender ___ Sore
 ___ Ache ___ Shooting ___ Weak ___ Numb Other: _____. How has your condition changed
 since your last exam? ___ Less Pain ___ Same Pain ___ More Pain ___ Increased Motion ___ Same Motion
 ___ Decreased Motion Other: _____.

___ LOW BACK ___ HIPS ___ LEGS ___ FEET ___ Pain ___ Spasm ___ Tenderness
 Other: _____. How has your condition changed since your last exam? ___ Less Pain
 ___ Same Pain ___ More Pain ___ Increased Motion ___ Same motion ___ Decreased Motion Other: _____.

CHECK YOUR NERVOUS SYSTEM COMPLAINTS: ___ Blurred Vision ___ Buzzing/Ringing in ears ___ Confusion
 ___ Convulsions ___ Depression/crying spells ___ Dizziness ___ Fainting ___ Paralysis ___ Headaches How often
 do you have headaches? _____ ___ Loss of Sleep ___ Low Resistance ___ Muscle Jerking ___ Numbness

PAIN LEVEL: On a scale of 0-10, with 0 being
 you're pain free and can function quite well,
 and 10 being you're in excruciating pain all the time,
 where would you rate the intensity of your pain?
 |-----|
 0 1 2 3 4 5 6 7 8 9 10
 NO PAIN LOW PAIN MODERATE PAIN INTENSE PAIN EXCRUCIATING

Describe any accident/injuries/diseases since your last visit—when? _____.

What makes your condition worse? ___ Nothing ___ Lifting ___ Trying to Stand ___ Standing ___ Walking
 ___ Sitting ___ Movement ___ Exercise ___ Inactivity ___ Work activities ___ Home activities Other: _____.

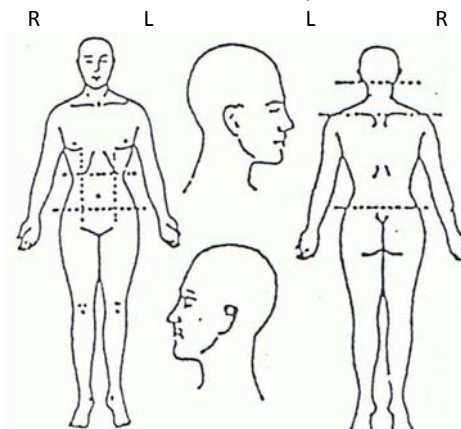
___ Exercise ___ Inactivity ___ Lying down ___ Sleep ___ Hot shower/bath ___ Stretching Other: _____.

ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:
 CODES: U=Unable P=Painful D=Difficult
 L=Limited N=Normal

Rate your satisfaction with the treatment received
 ___ Very Pleased ___ Pleased ___ Not Pleased

- | | |
|------------------------------------|---------------------|
| ___ Coughing or sneezing | ___ Climbing |
| ___ Getting in or out of a car | ___ Kneeling |
| ___ Bending forward to brush teeth | ___ Balancing |
| ___ Turning over in bed | ___ Dressing Self |
| ___ Walking short distances | ___ Sleeping |
| ___ Standing for more than 1 hour | ___ Stooping |
| ___ Sitting at a table | ___ Gripping |
| ___ Lying on back | ___ Pushing |
| ___ Lying flat on stomach | ___ Pulling |
| ___ Lying on side with knees bent | ___ Reaching |
| ___ Bending over forward | ___ Sexual Activity |

SHADE AND CODE AREA(S) OF COMPLAINT:
 USE CODES: P=Pain N=Numb S=Spasm



Symptoms are BETTER in: ___ AM ___ Midday ___ PM

Symptoms are WORSE in: ___ AM ___ Midday ___ PM

Symptoms do not change with time of day: _____.