**LOW BACK PAIN AND DISABILITY QUESTIONAIRE (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.

**SECTION 1 – PAIN INTENSITY**

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

**SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)**

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes me pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I do any washing and dressing without help.

**SECTION 3 – LIFTING**

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights of the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

**SECTION 4 -WALKING**

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

**SECTION 5 – SITTING**

- ☐ I can only sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half one.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

**SECTION 6 – STANDING**

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

**SECTION 7 – SLEEPING**

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

**SECTION 8 – SOCIAL LIFE**

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

**SECTION 9 – TRAVELING**

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

**SECTION 10 – CHANGING DEGREE OF PAIN**

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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 |
|---|---|---|---|---|---|---|---|---|---|

# 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.

**SECTION 1 – PAIN INTENSITY**

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)**

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

**SECTION 3 – LIFTING**

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

**SECTION 4 - READING**

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

**SECTION 5 – HEADACHES**

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

**SECTION 6 – CONCENTRATION**

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

**SECTION 7 – WORK**

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

**SECTION 8 – DRIVING**

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my care as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

**SECTION 9 - SLEEPING**

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless)

**SECTION 10 - RECREATION**

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

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 |
|---|---|---|---|---|---|---|---|---|---|

**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

____Coughing or sneezing
____Getting in or out of a car
____Bending forward to brush teeth
____Turning over in bed
____Walking short distances
____Standing for more than 1 hour
____Sitting at a table
____Lying on back
____Lying flat on stomach
____Lying on side with knees bent
____Bending over forward
____Climbing
____Kneeling
____Balancing
____Dressing Self
____Sleeping
____Stooping
____Gripping
____Pushing
____Pulling
____Reaching
____Sexual Activity

Symptoms are BETTER in: ____AM ____Midday ____PM

Symptoms are WORSE in: ____AM ____Midday ____PM

Symptoms do not change with time of day:_____.

Rate your satisfaction with the treatment received
____Very Pleased ____Pleased ____Not Pleased

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

R L L R