GLYNN
PHYSICAL THERAPY

PATIENT IDENTIFICATION AREA

OSWESTRY DISABILITY QUESTIONNAIRE LOWER BACK

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box, which most closely describes your current condition.**

Pain Intensity
- ❏ I can tolerate the pain I have without having to use pain medication.
- ❏ The pain is bad but I can manage without having to take pain medication.
- ❏ Pain medication provides me complete relief from pain.
- ❏ Pain medication provides me with moderate relief from pain.
- ❏ Pain medication provides me with little relief from pain.
- ❏ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing, etc.)
- ❏ I can take care of myself normally without causing increased pain.
- ❏ I can take care of myself normally but it increases my pain.
- ❏ It is painful to take care of myself and I am slow and careful.
- ❏ I need help but I am able to manage most of my personal care.
- ❏ I need help every day in most aspects of my care.
- ❏ I do not get dressed, wash with difficulty and stay in bed.

Lifting
- ❏ I can lift heavy weights without increased pain.
- ❏ I can lift heavy weights bu it causes increased pain.
- ❏ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. 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 only very light weights.
- ❏ I can not lift or carry anything at all.

Walking
- ❏ Pain does not prevent me from walking any distance.
- ❏ Pain prevents me from walking more than 1 mile.
- ❏ Pain prevents me from walking more than ½ milie.
- ❏ Pain prevents me from walking for more than ¼ mile.
- ❏ I can only walk with crutches and a cane.
- ❏ I am in bed most of the time.

Sitting
- ❏ I can 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 for mare than 1 hour.
- ❏ Pain prevents me from sitting for more than ½ hour.
- ❏ Pain prevents me from sitting for more than 10 minutes.
- ❏ Pain prevents me from sitting at all.

Standing
- ❏ I can stand as long as I want without increased pain.
- ❏ I can stand as long as I want but increases my pain.
- ❏ Pain prevents me from standing more than 1 hour.
- ❏ Pain prevents me from standing more than ½ hour.
- ❏ Pain prevents me from standing more than 10 minutes.
- ❏ Pain prevents me from standing at all.

Sleeping
- ❏ Pain does not prevent me from sleeping well.
- ❏ I can sleep well only by using pain medication.
- ❏ Even when I take pain medication, I sleep less than 6 hours.
- ❏ Even when I take pain medication, I sleep less than 4 hours.
- ❏ Even when I take pain medication, I sleep less than 2 hours.
- ❏ Pain prevents me from sleeping at all.

Social Life
- ❏ My social life is normal and does not increase my pain.
- ❏ My social life is normal, but it increases my level of pain.
- ❏ Pain prevents me from participating in more energetic activities, (ex. sports, dancing etc.)
- ❏ Pain prevents me from going out very often.
- ❏ Pain has restricted my social life to my home.
- ❏ I have hardly any social life because of my pain.

Traveling
- ❏ I can travel anywhere without increased pain.
- ❏ I can travel anywhere but it increases my pain.
- ❏ My pain restricts travel over 2 hours.
- ❏ My pain restricts my travel over 1 hour.
- ❏ My pain restricts my travel to short necessary journeys under ½ hour.
- ❏ My pain prevents all travel except for visits to the doctor/ therapist or hospital.

Employment/Homemaking
- ❏ My normal homemaking/job activities do not cause pain.
- ❏ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ❏ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming).
- ❏ Pain prevents me from doing anything but light duties.
- ❏ Pain prevents me from performing any job or homemaking chores.

Therapist Name:________________________________

Date: __________________ I/E F/U D/C

Score: ____________%

Score = Sum or responses ÷ Number possible x 100

Each item is socred from 0-5 from top to bottom

GLYNN

PHYSICAL THERAPY

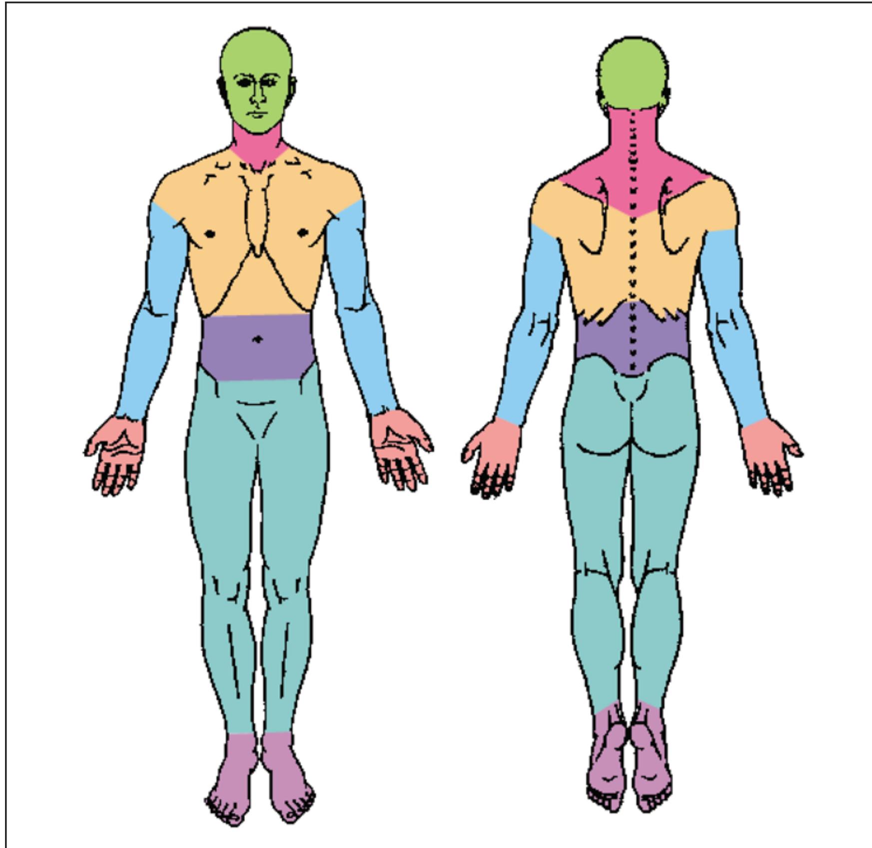
PATIENT IDENTIFICATION AREA

PAIN DIAGRAM AND RATING

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours.
You may also fill this part out at the time of your visit.

Key: Pins and Needles = 00000 Stabbing = ////////

Burning = xxxxx Deep Ache = zzzzzz



Please rate your *current* level of pain on the following scale (check one)

0❏ 1❏ 2❏ 3❏ 4❏ 5❏ 6❏ 7❏ 8❏ 9❏ 10❏
(no pain) (worst imaginable pain)

Please rate your *worst* level of pain int the last 24 hours on the following scale (check one)

0❏ 1❏ 2❏ 3❏ 4❏ 5❏ 6❏ 7❏ 8❏ 9❏ 10❏
(no pain) (worst imaginable pain)

Please rate your *best* level of pain in the last 24 hours on the following scale (check one)

0❏ 1❏ 2❏ 3❏ 4❏ 5❏ 6❏ 7❏ 8❏ 9❏ 10❏
(no pain) (worst imaginable pain)

Therapist Name:______________________________

Date: ________________ I/E F/U D/C