



REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>Section 1 — Pain Intensity</p> <p>A The pain comes and goes and is very mild. B The pain is mild and does not vary much. C The pain comes and goes and is moderate D The pain is moderate and does not vary much. E The pain comes and goes and is severe. F The pain is severe and does not vary much.</p>	<p>Section 6 — Standing</p> <p>A I can stand as long as I want without pain. B I have some pain while standing, but it does not increase with time. C I cannot stand for longer than one hour without increased pain. D I cannot stand for longer than 1/2 hour without increased pain. E I cannot stand for longer than ten minutes without increased pain. F I avoid standing, because it increases the pain right away.</p>
<p>Section 2 — Personal Care</p> <p>A I would not have to change my way of washing or dressing in order to avoid pain. B I do not normally change my way of washing or dressing even though it causes some pain. C Washing and dressing increases the pain, but I manage not to change my way of doing it. D Washing and dressing increases the pain and I find it necessary to change my way of doing it. E Because of the pain, I am unable to do some washing and dressing without help. F Because of the pain, I am unable to do any washing or dressing without help.</p>	<p>Section 7 — Sleeping</p> <p>A I get no pain in bed. B I get pain in bed, but it does not prevent me from sleeping well. C Because of pain, my normal night's sleep is reduced by less than one-quarter. D Because of pain, my normal night's sleep is reduced by less than one-half. E Because of pain, my normal night's sleep is reduced by less than three-quarters. F Pain prevents me from sleeping at all.</p>
<p>Section 3 — Lifting</p> <p>A I can lift heavy weights, without extra pain. B I can lift heavy weights, but it causes extra pain. C Pain prevents me from lifting heavy weights off the floor. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example, on a table. E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F I can only lift very light weights, at the most.</p>	<p>Section 8 — Social Life</p> <p>A My social life is normal and gives me no pain. B My social life is normal but increases the degree of my pain. C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. D Pain has restricted my social life and I do not go out very often. E Pain has restricted my social life to my home. F I have hardly any social life because of the pain.</p>
<p>Section 4 — Walking</p> <p>A Pain does not prevent me from walking any distance. B Pain does not prevent me from walking more than one mile. C Pain prevents me from walking more than 1/2 mile. D Pain prevents me from walking more than 1/4 mile. E I can only walk while using a cane or on crutches. F I am in bed most of the time and have to crawl to the toilet.</p>	<p>Section 9 — Traveling</p> <p>A I get no pain while traveling. B I get some pain while traveling, but none of my usual forms of travel make it any worse. C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. D I get extra pain while traveling which compels me to seek alternative forms of travel. E Pain restricts all forms of travel. F Pain prevents all forms of travel except that done lying down.</p>
<p>Section 5 — Sitting</p> <p>A I can sit in any chair as long as I like without pain. B I can only sit in my favorite chair as long as I like. C Pain prevents me from sitting more than one hour. D Pain prevents me from sitting more than 1/2 hour. E Pain prevents me from sitting more than ten minutes F Pain prevents me from sitting at all.</p>	<p>Section 10 — Changing Degree of Pain</p> <p>A My pain is rapidly getting better. B My pain fluctuates, but overall is definitely getting better. C My pain seems to be getting better, but improvement is slow at present. D My pain is neither getting better or worse. E My pain is gradually worsening. F My pain is rapidly worsening.</p>

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

Revised 9/11/92

Comments: _____

Patient Signature: _____ Date: _____



Advanced Integrative Medicine Patient Health Questionnaire

Patient Name _____ Date _____ ID # _____

If you have ever had a symptom in the past listed below, please check that symptom in the past column. If you are presently troubled by a particular symptom check the symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Conditions	Past	Present	Conditions
_____	_____	Abdominal Pain	_____	_____	Loss of Bladder Control
_____	_____	Abnormal Weight Gain/Loss	_____	_____	Low Back Pain
_____	_____	Angina	_____	_____	Mid Back Pain
_____	_____	Anorexia	_____	_____	Muscular Incoordination
_____	_____	Aortic Aneurysm	_____	_____	Neck Pain
_____	_____	Arthritis	_____	_____	Pain in Ankle or Foot
_____	_____	Asthma	_____	_____	Pain in Lower Leg or Knee
_____	_____	Bladder Infections	_____	_____	Pain in Upper Arm or Elbow
_____	_____	Blood Disorder	_____	_____	Pain in Upper Leg or Hip
_____	_____	Breast Soreness/Lump	_____	_____	Painful Urination
_____	_____	Cancer, explain	_____	_____	PMS
_____	_____	Chest Pains	_____	_____	Profuse Menstrual Flow
_____	_____	Chronic Cough	_____	_____	Prostate Problems
_____	_____	Chronic Sinusitis	_____	_____	Rapid Heart Beat
_____	_____	Colitis	_____	_____	Rheumatoid Arthritis
_____	_____	Constipation/Irregular bowel habits	_____	_____	Scoliosis
_____	_____	Convulsions	_____	_____	Shoulder Pain
_____	_____	Diabetes	_____	_____	Stroke (date _____)
_____	_____	Depression	_____	_____	Swelling, Stiffness of Joint(s)
_____	_____	Dermatitis/Eczema/Rash	_____	_____	Tinnitus (Ear Noises)
_____	_____	Difficulty in Swallowing	_____	_____	Tumor, Explained _____)
_____	_____	Dizziness	_____	_____	Ulcer
_____	_____	Emphysema (Chronic Lung Disorders)	_____	_____	Visual Disturbances
_____	_____	Endometriosis	_____	_____	Jaw Pain
_____	_____	Epilepsy	_____	_____	Wrist Pain
_____	_____	Excessive Thirst			
_____	_____	Fainting			
_____	_____	Frequent Urination			
_____	_____	General Fatigue			
_____	_____	Hand Pain (R___ L___)			
_____	_____	Headache			
_____	_____	Heart Attack (date _____)			
_____	_____	Heartburn/Indigestion			
_____	_____	Hepatitis			
_____	_____	High Blood Pressure			
_____	_____	Irritable Colon			

FAMILY HISTORY:

If any of your immediate family members have/had the following, please mark the appropriate line.

	MOTHER	FATHER	BROTHER(S)	SISTER(S)
Cancer	_____	_____	_____	_____
Retinal Detachment	_____	_____	_____	_____
Chronic Back Problems	_____	_____	_____	_____
Kidney Failure	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Rheumatoid Arthritis/Lupus	_____	_____	_____	_____

Have you ever had surgery or been hospitalized? ___No ___Yes _____

What medications are you currently taking? _____

Do you use tobacco? ___No ___Yes Do you drink alcohol? ___No ___Yes

Do you have or have you had an alcohol, drug, or any other kind of addiction or dependence? ___No ___Yes

In the past 90 days have you had: Doctor's Notes _____

Weight gain or loss of 10 or more pounds: No Yes _____

Any loss of appetite: No Yes _____

Fever, Chills, or Night Sweats: No Yes _____

x
Patient Signature _____ Date _____



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NAME (please print): _____ **Date:** _____

Age: _____ **Date of Birth:** _____ **Occupation:** _____

How long have you had low back pain? _____ **Years** _____ **Months** _____ **Weeks**

Is this your first episode of low back pain? _____ **Yes** _____ **No**

Use the letters below to indicate the type and location of your sensations right now.
Please remember to complete both sides of this form.

KEY: A= Ache B= Burning N= Numbness
 P= Pins & Needles S= Stabbing O= Other

