Name_____ Date_____ Patient # _____

Modified Oswestry Low Back Pain Disability Questionnaire

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** circle in each section that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please only mark the circle that most closely describes your current condition.**

Section 1 - Pain intensity

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

Section 2 - Personal Care (Washing, Dressing, etc.)

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

Section 3 - Lifting

- O I can lift heavy weights without increased pain.
- O I can lift heavy weights but it causes increased pain
- O Pain prevents me from lifting heavy weights off of the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- O Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- O I can lift only very light weights.
- O I can not lift or carry anything at all.

Section 4 - Walking

- O Pain does not prevent me from walking any distance.
- O Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- O Pain prevents me from walking more than 1/2 mile.
- O Pain prevents me from walking more than 1/4 mile.
- O I can walk only with crutches or a cane.
- O I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- O I can sit in any chair as long as I like.
- O I can only sit in my favorite chair as long as I like.
- O Pain prevents me from sitting for more than 1 hour.
- O Pain prevents me from sitting for more than 1/2 hour.
- O Pain prevents me from sitting for more than 10 minutes.
- O Pain prevents me from sitting at all.

Section 6 - Standing

- O I can stand as long as I want without increased pain.
- O I can stand as long as I want, but it pain increases my pain.
- O Pain prevents me from standing more than 1 hour.
- O Pain prevents me from standing more than 1/2 hour.
- O Pain prevents me from standing more than 10 minutes.
- O Pain prevents me from standing at all.

Section 7 - Sleeping

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

Section 8 - Social Life

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

Section 9 - Traveling

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

Section 10 - Employment/Homemaking

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

Scoring instructions for the physical therapists:

Section 1 - Pain intensity

O	My pain is mild and comes and goes.	*(A check at this level is scored as 0)*
O	The pain is mild and does not vary much.	*(A check at this level is scored as 1)*
O	The pain is moderate and comes and goes.	*(A check at this level is scored as 2)*
O	The pain is moderate and does not vary much.	*(A check at this level is scored as 3)*
O	The pain is severe and comes and goes.	*(A check at this level is scored as 4)*
O	The pain is severe and does not vary much.	*(A check at this level is scored as 5)*

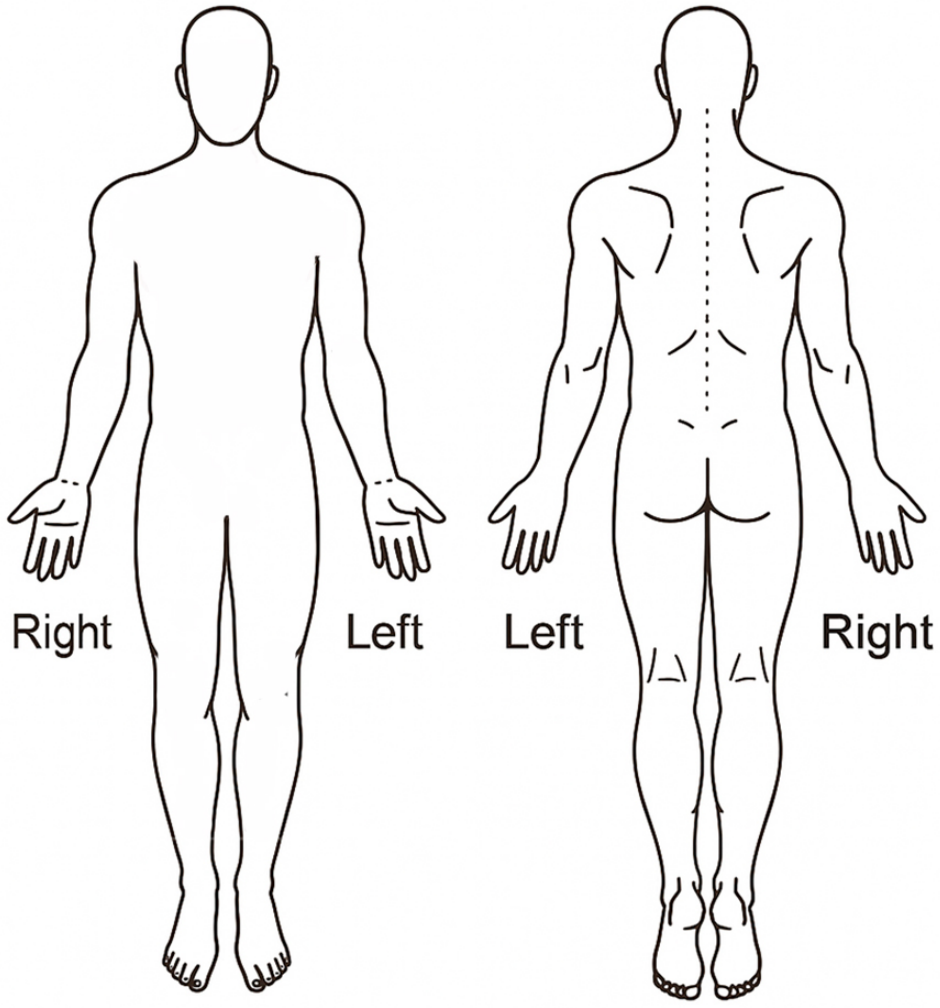
If an item in each section is filled out, add up the score from each section and double it to get the final percentage score
(eg. If total points from all 10 sections was 20, double the points and the final score would be 40. This is the score you report.)

If all items are not scored, then add up the total from all of the sections that were filled out, then divide by the total number of available points (i.e. if only 8 sections were answered, then the total possible points would be 40, not 50)
(eg. If total points from the 8 sections was 16, then calculate: 16/40 x 100 = 40. This is the score you report)

Patient Name: _____ Date: _____ / _____ / _____

Instructions:

On the body diagram below, please indicate where your symptoms are located at the present time.



Please rate your pain on a scale from 0 (no pain) to 10 (worst pain imaginable)

present: _____ lowest: _____ highest: _____

over the past 30 days:

Please briefly describe when your symptoms began, cause (if known), what makes you better and worse, treatment received, and any goals you may have for physical therapy.

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