

NAME: _____ DATE: _____ SCORE: _____

OSWESTRY DISABILITY INDEX 2.0

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer *every section*. Mark **one box only** in each section that most closely describes you **today**.

<p><i>SECTION 1 - Pain Intensity</i> A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Standing</i> A I can stand as long as I want without extra pain. B I can stand as long as I want but it gives me extra pain. C Pain prevents me from standing for more than 1 hour. D Pain prevents me from standing for more than 1/2 hour. E Pain prevents me from standing for more than 10 minutes. F Pain prevents me from standing at all.</p>
<p><i>SECTION 2 - Personal Care (washing, dressing, etc.)</i> A I can look after myself normally without causing extra pain. B I can look after myself normally but it is very painful. C It is painful to look after myself and I am slow and careful. D I need some help but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Sleeping</i> A My sleep is never disturbed by pain. B My sleep is occasionally disturbed by pain. C Because of pain I have less than 6 hours' sleep. D Because of pain I have less than 4 hours' sleep. E Because of pain I have less than 2 hours' sleep. F Pain prevents me from sleeping at all.</p>
<p><i>SECTION 3 - Lifting</i> 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, but I can manage if they are conveniently positioned, e.g. on a table. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can only lift very light weights, at the most. F I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Sex Life (if applicable)</i> A My sex life is normal and causes me no extra pain. B My sex life is normal, but causes some extra pain. C My sex life is nearly normal but is very painful. D My sex life is severely restricted by pain. E My sex life is nearly absent because of pain. F Pain prevents any sex life at all.</p>
<p><i>SECTION 4 - Walking</i> A Pain does not prevent me from walking any distance. B Pain prevents me from walking more than one mile. C Pain prevents me from walking more than 1/4 mile. D Pain prevents me from walking more than 100 yards. E I can only walk while using a stick or crutches. F I am in bed most of the time and have to crawl to the toilet.</p>	<p><i>SECTION 9 - Social Life</i> A My social life is normal and causes me no extra pain. B My social life is normal, but increases the degree of pain. C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc. D Pain has restricted my social life and I do not go out as often. E Pain has restricted my social life to my home. F I have no social life because of the pain.</p>
<p><i>SECTION 5 - Sitting</i> A I can sit in any chair as long as I like. B I can only sit in my favorite chair as long as I like. C Pain prevents me from sitting more than 1 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><i>SECTION 10 - Traveling</i> A I can travel anywhere without pain. B I can travel anywhere but I gives extra pain. C Pain is bad but I manage journeys over 2 hours. D Pain restricts me to journeys of less than 1 hour. E Pain restricts me to short necessary journeys under 30 minutes. F Pain prevents me from traveling except to receive treatment.</p>

COMMENTS: _____

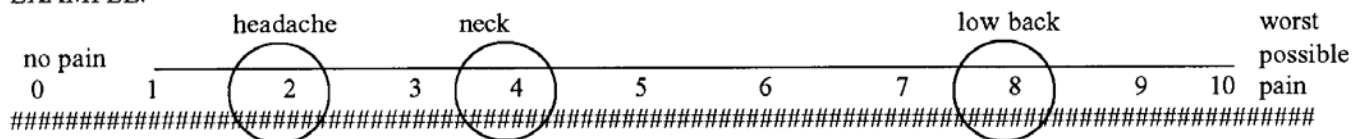
NAME _____ AGE _____ DATE _____

QUADRUPLE VISUAL ANALOGUE SCALE

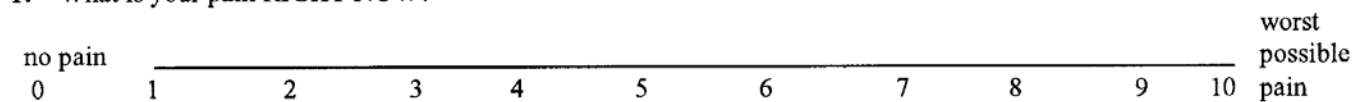
INSTRUCTIONS: Please *circle* the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last _____ (Doctor: fill in the desired time interval) as your reference. If you have completed this form before, indicate your average pain level *after* the last time you completed this form (Applies to Question #2.).

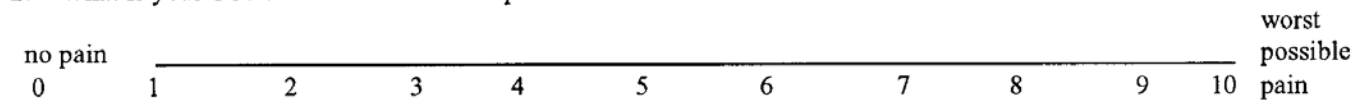
EXAMPLE:



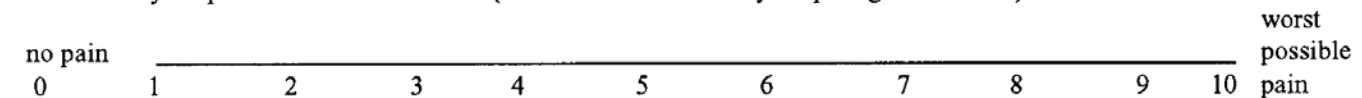
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

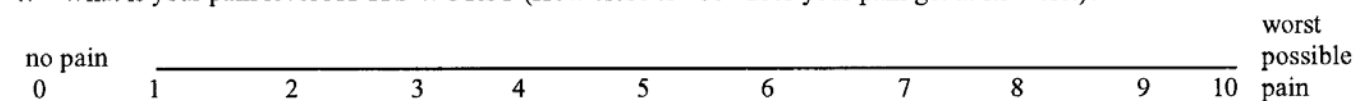


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

For Doctor Use Only:

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

TOTAL SCORE _____