

Name: _____,
Last First & Middle

DOB: _____

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly 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 (eg. washing, dressing)

- 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 can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, 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 me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra 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. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

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EQ-5D-3L

By circling one statement in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (*e.g. work, study, housework, family or leisure activities*)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

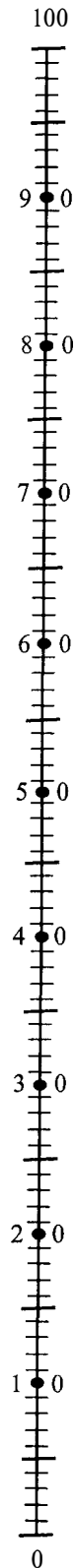
Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Best imaginable health state



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Your Health and Well-Being

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
	▼	▼	▼
a <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Climbing <u>several</u> flights of stairs.....	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Climbing <u>one</u> flight of stairs.....	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Bending, kneeling, or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Walking <u>more than a mile</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Walking <u>several hundred yards</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Walking <u>one hundred yards</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Bathing or dressing yourself.....	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
-----------------	------------------	------------------	----------------------	------------------



- a Cut down on the amount of time you spent on work or other activities ₁ ₂ ₃ ₄ ₅
- b Accomplished less than you would like ₁ ₂ ₃ ₄ ₅
- c Were limited in the kind of work or other activities ₁ ₂ ₃ ₄ ₅
- d Had difficulty performing the work or other activities (for example, it took extra effort) ₁ ₂ ₃ ₄ ₅

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
-----------------	------------------	------------------	----------------------	------------------



- a Cut down on the amount of time you spent on work or other activities ₁ ₂ ₃ ₄ ₅
- b Accomplished less than you would like..... ₁ ₂ ₃ ₄ ₅
- c Did work or other activities less carefully than usual..... ₁ ₂ ₃ ₄ ₅

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe
▼	▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	▼	▼	▼	▼	▼
a Did you feel full of life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b Have you been very nervous?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
d Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
e Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
f Have you felt downhearted and depressed?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
g Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
h Have you been happy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
i Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
	▼	▼	▼	▼	▼
a I seem to get sick a little easier than other people.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b I am as healthy as anybody I know.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c I expect my health to get worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d My health is excellent.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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PAIN QUESTIONNAIRE

1. Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness

"S" = stabbing

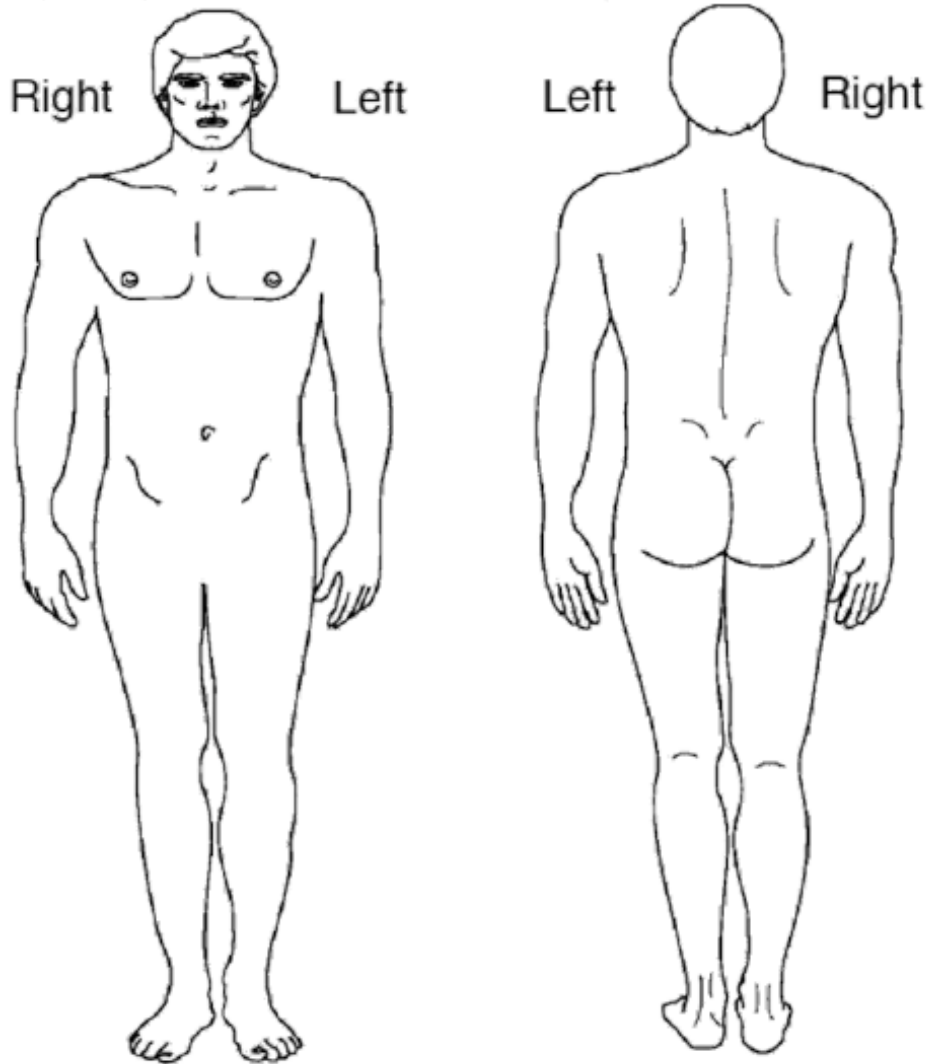
"B" = burning

"P" = pins and
needles

"A" = aching

"W" = weakness

"T" = tingling



2. What makes your pain worse? _____

3. What makes your pain better? _____

4. Have you tried? (select all that apply)

- Physical Therapy Oral Steroids Epidural Steroid Injections Chiropractor
 Trigger Point Injections Lyrica Gabapentin Muscle Relaxers
 Over the counter/non-prescription pain medications Prescription pain medications

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BACK/LEG PAIN ASSESSMENT TOOL

Please take a moment to review the scales shown below and select appropriately. *Note:* the left scale relates to back pain and the right scale relates to leg pain.

Part 1.

- A. I do NOT have either back or leg pain
- B. I have back and/or leg pain

If you answered A., please stop here. If you answered B. please complete Parts 2 and 3.

Part 2. Please select one:

- Back pain: 0%; Leg Pain: 100%
- Back pain: 10%; Leg Pain: 90%
- Back pain: 25%; Leg Pain: 75%
- Back pain: 50%; Leg Pain: 50%
- Back pain: 75%; Leg Pain: 25%
- Back pain: 90%; Leg Pain: 10%
- Back pain: 100%; Leg Pain: 0%

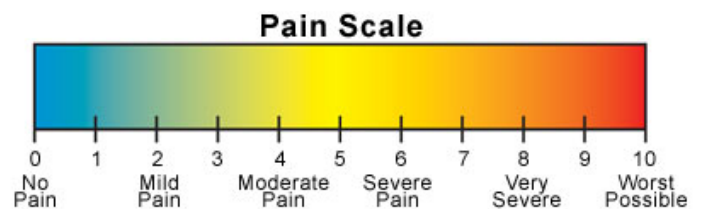
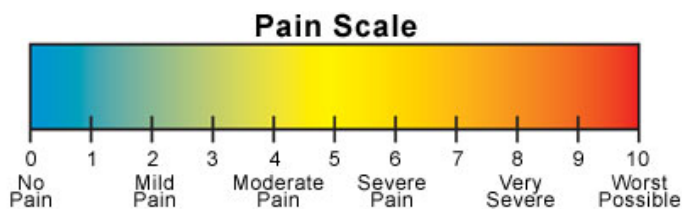
Part 3.

BACK PAIN

LEG PAIN

Circle the number that best describes the level of **back pain** you have experienced in the past month

Circle the number that best describes the level of **leg pain** you have experienced in the past month



0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

If pain, how long has **back pain** been present?

If pain, how long has **leg pain** been present?

- 1 year
- 5 years
- 10 years
- 15 years
- 20 years or greater

- 1 year
- 5 years
- 10 years
- 15 years
- 20 years or greater

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NECK/ARM PAIN ASSESSMENT TOOL

Please take a moment to review the scales shown below and select appropriately. *Note: the left scale relates to Neck pain and the right scale relates to Arm pain.*

Part 1.

- A. I do NOT have either Neck or Arm pain
B. I have Neck and/or Arm pain

If you answered A., please stop here. If you answered B. please complete Parts 2 and 3.

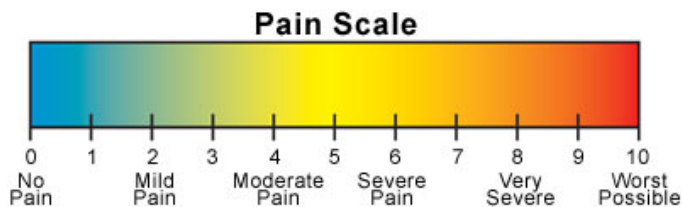
Part 2. Please select one:

- Neck pain: 0%; Arm Pain: 100%
 Neck pain: 10%; Arm Pain: 90%
 Neck pain: 25%; Arm Pain: 75%
 Neck pain: 50%; Arm Pain: 50%
 Neck pain: 75%; Arm Pain: 25%
 Neck pain: 90%; Arm Pain: 10%
 Neck pain: 100%; Arm Pain: 0%

Part 3.

NECK PAIN

Circle the number that best describes the level of **Neck pain** you have experienced in the past month



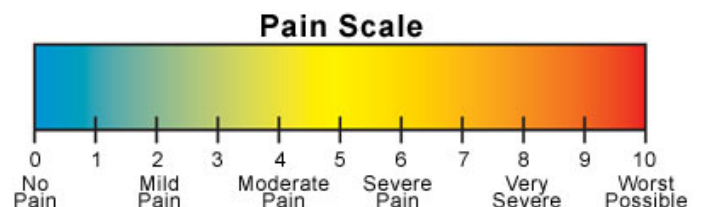
0 1 2 3 4 5 6 7 8 9 10

If pain, how long has **Neck pain** been present?

- 1 year
 5 years
 10 years
 15 years
 20 years or greater

ARM PAIN

Circle the number that best describes the level of **Arm pain** you have experienced in the past month



0 1 2 3 4 5 6 7 8 9 10

If pain, how long has **Arm pain** been present?

- 1 year
 5 years
 10 years
 15 years
 20 years or greater

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PLEASE COMPLETE FOR NECK PAIN ONLY

Neck Disability Index

Instructions

This questionnaire has been designed to give your health practitioner 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 realise you may consider that two of the statements in any one section relate to you, but please 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)

- 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 cannot read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

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PLEASE COMPLETE FOR NECK PAIN ONLY

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 moderate headaches which come frequently.
- 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 cannot 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 car as long as I want with moderate pain in my neck.
- I cannot 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 cannot 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 cannot do any recreation activities at all.