EXPERT SPINE CARE
INNOVATIVE MINIMALLY INVASIVE TREATMENT

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________________

This questionnaire has been designed to give your Physician information as to how your back pain has affected your ability to manage everyday life.
Please answer every question by placing a mark in the box that best describes your condition today.
During the past 4 weeks…

Section 1 – Pain Intensity	Section 6 – Concentration
□ I have not 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	□ 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 2 – Personal Care (Washing, Dressing)	Section 7 – Work
□ I can look after myself normally without causing extra pain □ I can look after myself normally but it is very painful □ 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	□ 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 3 – Lifting	Section 8 – Driving
□ I can lift heavy weights without extra pain □ I can lift heavy weights but it gives extra pain □ Pain prevents me form lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g. on a table) □ Pain prevents me from lifting heavy weights, but I can manage lift to medium weights if they are conveniently positioned □ I can lift only very light weights □ I cannot lift or carry anything at all	□ 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 4 – Reading	Section 9 – Sleeping
□ I can read as much as I want with no pain in my neck □ I can reach as much as I want with slight pain in my neck □ I can reach 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	□ I have no trouble sleeping □ My sleep is slightly disturbed (less than 1 hour sleepless) □ My sleep is mildly disturbed (1-2 hours sleepless) □ My sleep is moderately disturbed (2-3 hours sleepless) □ My sleep is greatly disturbed (3-5 hours sleepless) □ My sleep is completely disturbed (5-7 hours sleepless)
Section 5 – Headaches	Section 10 – Recreation
□ 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 most of the time	□ I am able to engage in all my recreational activities with no neck pain at all □ I am able to engage in all my recreational activities with some neck pain □ I am able to engage in most, but not all, of my usual recreational activities because pain in my neck □ I am able to engage in a few of my usual recreational activities because of pain in my neck □ I can hardly do any recreational activities because of pain in my neck □ I cannot do any recreation activities at all
Previous Treatment	
Over the past 3 months have you received treatment, tablets, or medicines of any kind for your back or leg pain (Please tick the appropriate box)	□ Yes □ No
….if yes, please state the type of treatment you have received	Briefly Describe