Oswestry Disability Index for Back Pain

Name: **Today's Date**:

Please Read Carefully: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage your everyday activities. Please circle the NUMBER that most closely describes your situation.

1 Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

2 Personal Care (Washing, Dressing, etc.)

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

3 Lifting

0. I can lift heavy weights without increased pain.
1. I can lift heavy weights but it causes increased pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I can not lift or carry anything at all.

4 Walking

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than ¼ mile.
4. I can only walk using a cane or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

5 Sitting

0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me sitting more than 1 hour.
3. Pain prevents me sitting more than ½ hour.
4. Pain prevents me sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

6 Standing

0. I can stand as long as I want without increased pain.
1. I can stand as long as I want but increases my pain.
2. Pain prevents me from standing more than 1 hour.
3. Pain prevents me from standing more than ½ hour.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

7 Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is greatly disturbed (5-7 hours sleepless).

8 Social Life

0. My social life is normal and does not increase my pain.
1. My social life is normal, but increases my level of pain.
2. Pain prevents me from participating in more energetic activities (ex: dancing, sports, etc.)
3. Pain prevents me from going out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of my pain.

9 Traveling

0. I can travel anywhere without increased pain.
1. I can travel anywhere but it increases my pain.
2. My pain restricts travel over 2 hours.
3. My pain restricts my travel over 1 hour.
4. My pain restricts my travel to short necessary journeys under ½ hour.
5. My pain prevents all travel except for visits to the doctor/therapist or hospital.

10 Work /Homemaking

0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2. I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex: lifting, vacuuming).
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from performing any job or homemaking chores.

FOTO Patient Intake Survey Lumbar Spine

Name: Date:

Please Read Carefully: Answer each question based on the p**roblem for which you are receiving treatment**. Mark which column best describes how you are able to do each activity. Please answer each question even if you do not do or have not done this activity. Make your best guess as to which response is most accurate.

Because of your affected back do you or would you have any difficulty…	Unable to do	Extreme difficulty	Quite a bit of difficulty	Moderate Difficulty	A little bit of difficulty	No Difficutly
1. Any of your usual work, housework, or school activities						
2. Your usual hobbies, recreational, or sporting activites						
3. Performing heavy activities around your home						
4. Bending or stooping						
5. Lifting a box of groceries from the floor						

	Yes, limited a lot	Yes, limited a little	No, not limited at all
6. Vigorous activites, such as running, lifting heavy objects, participating in strenuous sports			
7. Moderate actiivites, such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
8. Lifting or carrying groceries			
9. Attending social or cultural events			
10. Getting in and out of your chair			