

# Revised Oswestry Low Back Pain Disability Questionnaire

From N. Hudson, K. Tome-Nicholson, A. Breen; 1989 rev. 09/11/92

Please mark the ONE choice from EACH group that best describes your problem right now.

<p><b>PAIN INTENSITY</b></p> <p><input type="checkbox"/>A. The pain comes and goes and is very mild.</p> <p><input type="checkbox"/>B. The pain is mild and does not vary much.</p> <p><input type="checkbox"/>C. The pain comes and goes and is moderate.</p> <p><input type="checkbox"/>D. The pain is moderate and does not vary much.</p> <p><input type="checkbox"/>E. The pain comes and goes and is severe.</p> <p><input type="checkbox"/>F. The pain is severe and does not vary much.</p>	<p><b>STANDING</b></p> <p><input type="checkbox"/>A. I can stand as long as I want without pain.</p> <p><input type="checkbox"/>B. I have some pain while standing, but it does not increase with time.</p> <p><input type="checkbox"/>C. I cannot stand for longer than one hour without increasing pain.</p> <p><input type="checkbox"/>D. I cannot stand for longer than ½ hour without increasing pain.</p> <p><input type="checkbox"/>E. I cannot stand for longer than ten minutes without increasing pain.</p> <p><input type="checkbox"/>F. I avoid standing, because it increases the pain straight away.</p>
<p><b>PERSONAL CARE</b></p> <p><input type="checkbox"/>A. I would not have to change my way of washing or dressing in order to avoid pain.</p> <p><input type="checkbox"/>B. I do not normally change my way of washing or dressing even though it causes some pain.</p> <p><input type="checkbox"/>C. Washing and dressing increases the pain, but I manage not to change my way of doing it.</p> <p><input type="checkbox"/>D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.</p> <p><input type="checkbox"/>E. Because of the pain, I am unable to do some washing and dressing without help.</p> <p><input type="checkbox"/>F. Because of the pain, I am unable to do any washing or dressing without help.</p>	<p><b>SLEEPING</b></p> <p><input type="checkbox"/>A. I get no pain in bed.</p> <p><input type="checkbox"/>B. I get pain in bed, but it does not prevent me from sleeping well.</p> <p><input type="checkbox"/>C. Because of pain, my normal night's sleep is reduced by less than one-quarter.</p> <p><input type="checkbox"/>D. Because of pain, my normal night's sleep is reduced by less than one-half.</p> <p><input type="checkbox"/>E. Because of pain, my normal night's sleep is reduced by less than three-quarters.</p> <p><input type="checkbox"/>F. Pain prevents me from sleeping at all.</p>
<p><b>LIFTING</b></p> <p><input type="checkbox"/>A. I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/>B. I can lift heavy weights, but it causes extra pain.</p> <p><input type="checkbox"/>C. Pain prevents me from lifting heavy weights off the floor.</p> <p><input type="checkbox"/>D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.</p> <p><input type="checkbox"/>E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/>F. I can only lift very light weights, at the most.</p>	<p><b>SOCIAL LIFE</b></p> <p><input type="checkbox"/>A. My social life is normal and gives me no pain.</p> <p><input type="checkbox"/>B. My social life is normal, but increases the degree of my pain.</p> <p><input type="checkbox"/>C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.</p> <p><input type="checkbox"/>D. Pain has restricted my social life and I do not go out very often.</p> <p><input type="checkbox"/>E. Pain has restricted my social life to my home.</p> <p><input type="checkbox"/>F. I have hardly any social life because of the pain.</p>
<p><b>WALKING</b></p> <p><input type="checkbox"/>A. Pain does not prevent me from walking any distance.</p> <p><input type="checkbox"/>B. Pain prevents me from walking more than one mile.</p> <p><input type="checkbox"/>C. Pain prevents me from walking more than ½ mile.</p> <p><input type="checkbox"/>D. Pain prevents me from walking more than 1/4 mile.</p> <p><input type="checkbox"/>E. I can only walk while using a cane or on crutches.</p> <p><input type="checkbox"/>F. I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>TRAVELING</b></p> <p><input type="checkbox"/>A. I get no pain while traveling.</p> <p><input type="checkbox"/>B. I get some pain while traveling, but none of my usual forms of travel make it any worse.</p> <p><input type="checkbox"/>C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</p> <p><input type="checkbox"/>D. I get extra pain while traveling which compels me to seek alternative forms of travel.</p> <p><input type="checkbox"/>E. Pain restricts all forms of travel.</p> <p><input type="checkbox"/>F. Pain prevents all forms of travel except that done lying down.</p>
<p><b>SITTING</b></p> <p><input type="checkbox"/>A. I can sit in any chair as long as I like without pain.</p> <p><input type="checkbox"/>B. I can only sit in my favorite chair as long as I like.</p> <p><input type="checkbox"/>C. Pain prevents me from sitting more than one hour.</p> <p><input type="checkbox"/>D. Pain prevents me from sitting more than ½ hour.</p> <p><input type="checkbox"/>E. Pain prevents me from sitting more than ten minutes.</p> <p><input type="checkbox"/>F. Pain prevents me from sitting at all.</p>	<p><b>CHANGING DEGREE OF PAIN</b></p> <p><input type="checkbox"/>A. My pain is rapidly getting better.</p> <p><input type="checkbox"/>B. My pain fluctuates, but overall is definitely getting better.</p> <p><input type="checkbox"/>C. My pain seems to be getting better, but improvement is slow at present.</p> <p><input type="checkbox"/>D. My pain is neither getting better nor worse.</p> <p><input type="checkbox"/>E. My pain is gradually worsening.</p> <p><input type="checkbox"/>F. My pain is rapidly worsening.</p>

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Disability Index Score: % \_\_\_\_\_