

MODIFIED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE¹

Section 1: To be completed by patient

Name: _____

Age: _____

Date: _____

Occupation: _____

Number of days of back pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

Pain Intensity

- _____ The pain is mild and comes and goes.
- _____ The pain is mild and does not vary much.
- _____ The pain is moderate and comes and goes.
- _____ The pain is moderate and does not vary much.
- _____ The pain is severe and comes and goes.
- _____ The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.)

- _____ I do not have to change the way I wash and dress myself to avoid pain.
- _____ I do not normally change the way I wash or dress myself even though it causes some pain.
- _____ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- _____ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- _____ Because of my pain I am partially unable to wash and dress without help.
- _____ Because of my pain I am completely unable to wash or dress without help.

Lifting

- _____ I can lift heavy weights without increased pain.
- _____ I can lift heavy weights but it causes increased pain
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- _____ I can lift only very light weights.
- _____ I can not lift or carry anything at all.

Walking

- _____ I have no pain when walking.
- _____ I have pain when walking, but I can still walk my required normal distances.
- _____ Pain prevents me from walking long distances.
- _____ Pain prevents me from walking intermediate distances.
- _____ Pain prevents me from walking even short distances.
- _____ Pain prevents me from walking at all.

Sitting

- _____ Sitting does not cause me any pain.
- _____ I can only sit as long as I like providing that I have my choice of seating surfaces.
- _____ Pain prevents me from sitting for more than 1 hour.
- _____ Pain prevents me from sitting for more than 1/2 hour.
- _____ Pain prevents me from sitting for more than 10 minutes.
- _____ Pain prevents me from sitting at all.

