

## LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize 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 can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

### Section 2 -- Personal Care (Washing, Dressing, etc.)

- 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 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from 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 almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.  
 (Score      x 2) / (      Sections x 10) =                      %ADL

### 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 extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

### Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### Section 8 – 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. dancing.
- 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 9 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

### Section 10 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments \_\_\_\_\_

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor 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 ONE box** which applies to you. We realize 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, etc.)

- 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.
- I can't 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.

### Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.  
 (Score \_\_\_ x 2) / ( \_\_\_ Sections x 10) = \_\_\_\_\_ %ADL

### 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 can't do any work at all.

### Section 8 – Driving

- I 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 can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't 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 moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 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 can't do any recreation activities at all.

Comments \_\_\_\_\_ %ADL

# HEADACHE DISABILITY INDEX

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SCORES TOTAL: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
(100) (52) (48)

**INSTRUCTIONS: Please CIRCLE the correct response:**

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

**INSTRUCTIONS: PLEASE READ CAREFULLY:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

# SYMPTOM DIAGRAM

Name \_\_\_\_\_ Number N/A Date \_\_\_\_\_

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

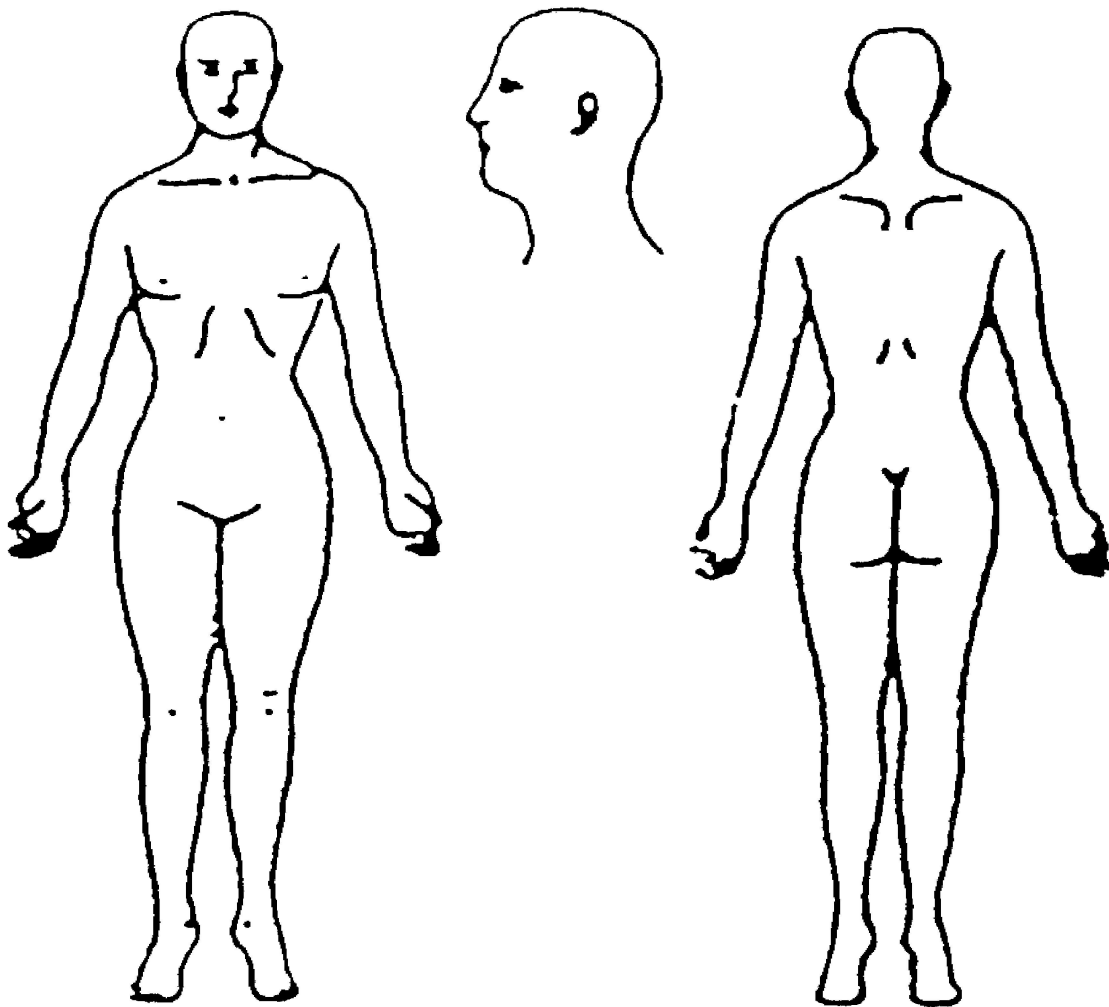
Aches  $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///



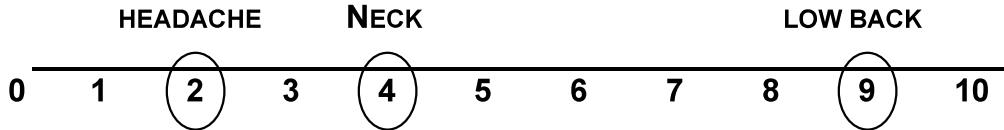
# QUADRUPLE VISUAL ANALOGUE SCALE

Name \_\_\_\_\_ Number N/A Date \_\_\_\_\_

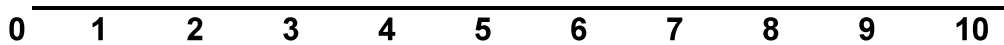
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

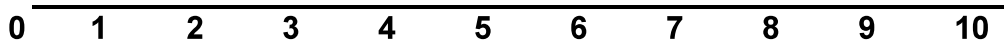
**EXAMPLE:**



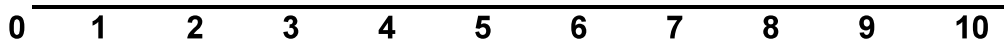
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

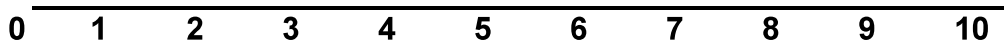


3. What is your pain AT ITS BEST (How close to “0” does your pain get at its best)?



What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

4. What is your pain AT ITS WORST (How close to “10” does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

## SHOULDER PAIN SCORE

Name \_\_\_\_\_ Number N/A Date \_\_\_\_\_

	<u>None</u>	<u>Light</u>	<u>Average</u>	<u>Severe</u>
Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightly pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems caused by pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incapability of lying on the painful side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>None</u>	<u>Till halfway the upper arm</u>	<u>Till the elbow</u>	<u>Past the elbow</u>
Degree of radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0  Unbearable pain is 100