



Oswestry Disability Index for Lower Back Pain

Patient Acct # _____
Doctor # _____
Reviewed By _____

Patient Name: _____ File # _____ Date _____

Please Read: This questionnaire has been designed to give the doctor information on how your pain has affected your ability to manage everyday life. **PLEASE ANSWER EVERY SECTION AND MARK IN EACH SECTION ONLY ONE ANSWER** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes you

SECTION 1- PAIN INTENSITY

- I can tolerate the pain I have without pain killers.
- The pain is bad but I manage without pain killers.
- Pain killers give me complete relief of pain.
- Pain killers give me moderate relief of pain.
- Pain killers give me very little relief of pain.
- Pain killers have no effect on pain and I do not use them.

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally, without extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, but I am slow and careful.
- I need some help but manage most of my personal care.
- I need some help everyday 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 causing pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off of the floor, but I manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenient.
- I can lift light weights only.
- 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 1 Mile.
- Pain prevents me from walking more than ½ Mile.
- Pain prevents me from walking more than ¼ Mile.
- I can only walk using a stick/cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5-SITTING

- I can still sit in a 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 an hour.
- Pain prevents me from sitting more than a ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

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 an hour.
- Pain prevents me from standing more than a ½ hr.
- Pain prevents me from standing more than 10 min.
- 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.
- Even when I take tablets, I have less than 4 hours.
- Even when I take tablets, I have less than 2 hours.
- Pain prevents me from sleeping at all.

SECTION 8- EMPLOYMENT/HOMEMAKING

- Job/homemaking causes no extra pain.
- Job/homemaking increases pain, but I can still perform.
- Can perform most duties, pain prevents heavier activity.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from doing ANY job/homemaking.

SECTION 9- SOCIAL LIFE

- My social life is normal and causes no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my life apart from limiting my more energetic interests (dancing, etc.).
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life and I do not go out.
- I have no social life because of pain.

SECTION 10- Traveling

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

Total: _____

Patient Signature _____

Date _____