

# Oswestry Disability Index 2.1a

Patient Label  
(Office Use Only)

First Name

 /  / 

Today's Date (mm/dd/yyyy)

Last Name

 /  / 

Date of Birth (mm/dd/yyyy)

Office Use Only

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer **every section**. Fill in the **one bubble only** in each section that most closely describes you **today**.

## 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 is very painful.
- 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, 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, e.g. 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 only very light weights.
- I cannot lift or carry anything at all.

## Section 4 - Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than one mile.
- Pain prevents me walking more than a quarter of a mile.
- Pain prevents me walking more than 100 yards.
- 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 sit in my favourite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting for more than half an hour.
- Pain prevents me from sitting for 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 me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than half an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

## Section 7 - Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours of sleep.
- Because of pain I have less than 4 hours of sleep.
- Because of pain I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

## Section 8 - Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

## Section 9 - Social life

- My social life is normal and causes 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., sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

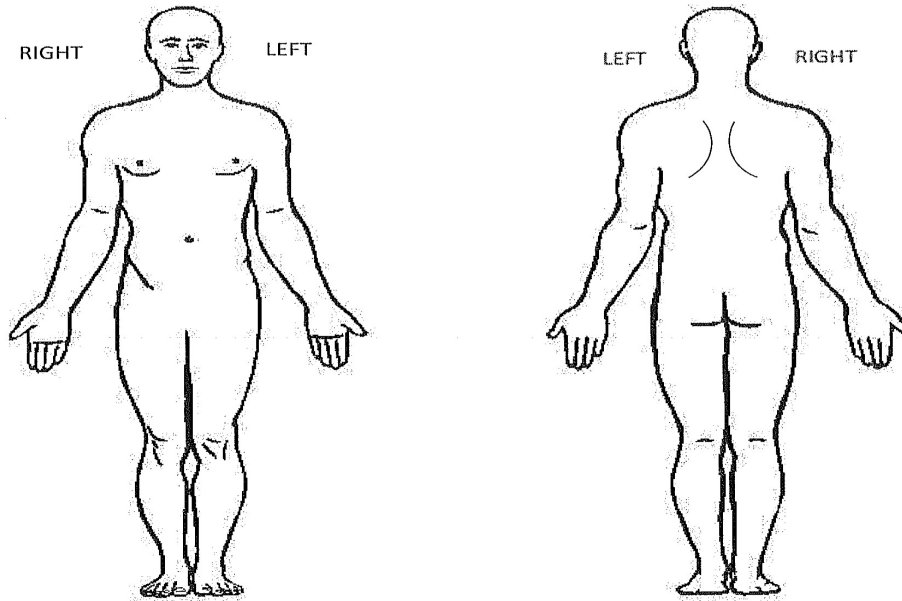
## Section 10 - Travelling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Please check the parts of the body where you have pain



How do you rate your pain?



Please **CHECK** your answers:

|   |  |  |   |
|---|--|--|---|
| <b>Describe your pain:</b><br>Aching<br>Burning<br>Deep, Diffuse<br>Discomforting<br>Dull<br>Electrical<br>Localized<br>Piercing, Sharp<br>Shooting<br>Stabbing<br>Superficial<br>Throbbing | <b>Timing of your pain:</b><br>Continuous and Constant<br>Continuous, but variable intensities<br>Intermittent<br>Progressive<br>Variable<br>Daily | <b>Aggravated by:</b><br>Any activity<br>Stairs<br>Daily activities<br>Driving<br>Exercise<br>1 <sup>st</sup> steps in the morning<br>Leaning back<br>Leaning forward<br>Physical activity<br>Sitting<br>Standing<br>Walking | <b>Relieved by:</b><br>Brace<br>Heat<br>Ice<br>Injections<br>Leaning back<br>Leaning forward<br>Lying Down<br>Medications<br>Procedures<br>Sitting<br>Standing<br>Walking |
|   | <b>Do you have these symptoms:</b><br>Numbness<br>Tingling<br>Weakness<br>Pain with coughing or having a BM<br>Loss of bowel or bladder control    |  |   |

Have you had physical therapy? \_\_\_\_\_ How long did you participate? \_\_\_\_\_ Did it help? \_\_\_\_\_

Activities of Daily Living : Not affected or Unable to perform (Specify: \_\_\_\_\_)

Difficulty sleeping? Yes or No (If yes, is it because of pain? Yes or No)

Procedure \_\_\_\_\_ and \_\_\_\_\_% relief

Are you on blood thinners? Yes or No (if yes, list: \_\_\_\_\_)

Are you currently working? Yes or No Is your blood pressure controlled? Yes or No

# REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Are you **CURRENTLY** experiencing any of the following symptoms

**Constitutional:**

- No  Yes Fever
- No  Yes Weight Gain
- No  Yes Weight Loss
- No  Yes Other: \_\_\_\_\_

**Genitourinary:**

- No  Yes Painful Urination
- No  Yes Blood in Urine
- No  Yes Urinary Retention
- No  Yes Other: \_\_\_\_\_

**Psychiatric:**

- No  Yes Anxiety
- No  Yes Depression
- No  Yes Insomnia
- No  Yes Other: \_\_\_\_\_

**Head, Eyes, Ears, Nose & Throat:**

- No  Yes Ear Drainage
- No  Yes Nasal Drainage
- No  Yes Sinus Pressure
- No  Yes Sore Throat
- No  Yes Other: \_\_\_\_\_

**Reproductive:**

- No  Yes Erectile Dysfunction
- No  Yes Other: \_\_\_\_\_

**Musculoskeletal:**

- No  Yes Back Pain
- No  Yes Joint Pain
- No  Yes Joint Swelling
- No  Yes Muscle Weakness
- No  Yes Neck Pain
- No  Yes Other: \_\_\_\_\_

**Respiratory:**

- No  Yes Chronic Cough
- No  Yes Cough
- No  Yes Known TB Exposure
- No  Yes Shortness of Breath
- No  Yes Wheezing
- No  Yes Other: \_\_\_\_\_

**Integumentary:**

- No  Yes Brittle Hair
- No  Yes Brittle Nails
- No  Yes Hair Loss
- No  Yes Itching
- No  Yes Rash
- No  Yes Other: \_\_\_\_\_

**Hematologic/Lymphatic:**

- No  Yes Easy Bleeding
- No  Yes Easy Bruising
- No  Yes Other: \_\_\_\_\_

**Cardiovascular:**

- No  Yes Chest Pain
- No  Yes Swelling
- No  Yes Palpitations
- No  Yes Other: \_\_\_\_\_

**Neurological:**

- No  Yes Dizziness
- No  Yes Extremity Numbness
- No  Yes Extremity Weakness
- No  Yes Trouble Walking
- No  Yes Headache
- No  Yes Memory Loss
- No  Yes Seizures
- No  Yes Tremors
- No  Yes Other: \_\_\_\_\_

**Gastrointestinal:**

- No  Yes Constipation
- No  Yes Diarrhea
- No  Yes Nausea
- No  Yes Vomiting
- No  Yes Other: \_\_\_\_\_

Southern Pain  
AND Neurological

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## OPIOID SAFETY SURVEY

Because there is an addiction risk with opioid medicines, we must understand your history before we set a treatment plan for you. Please circle "Yes" or "No" in the chart below as the case applies to you today or in the past.

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **( M / F )**

| Circle YES or NO for each question  |     |    |
|---|-----|----|
| <b>Do YOU have a history of substance abuse of any of the following?</b>                |     |    |
| Alcohol   | YES | NO |
| Illegal Drugs   | YES | NO |
| Prescription Drugs  | YES | NO |
| <b>Do you have a FAMILY history of substance abuse of any of the following?</b>         |     |    |
| Alcohol   | YES | NO |
| Illegal Drugs   | YES | NO |
| Prescription Drugs  | YES | NO |
| <b>Are you between 16-45 years old?</b>   | YES | NO |
| <b>Were you sexually abused as a child?</b>   | YES | NO |
| <b>Have you ever been diagnosed with any of the following mental health conditions?</b> |     |    |
| ADD, OCD, bipolar, schizophrenia  | YES | NO |
| Depression  | YES | NO |

# Southern Pain and Neurological

Were you exposed to anyone with a positive COVID 19 test?      Yes      No

Have you been tested for COVID 19?      Yes      No

When were you tested? \_\_\_\_\_

Did you test positive?      Yes      No

If positive, have you had a negative test recorded?      Yes      No

Do you have any symptoms today?      Yes      No

Have you previously had any symptoms?      Yes      No

Symptoms:              Cough              Shortness of breath or difficulty breathing

Chills              Muscle Pain              Headaches

Sore Throat              NEW loss of taste or smell

Fever:              When \_\_\_\_\_              Temp \_\_\_\_\_

Any other symptoms, please list:

Today's Temp: \_\_\_\_\_              Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_              DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_