Oswestry Disability Index 2.1a

Patient Label
(Office Use Only)

First Name

Today's Date (mm/dd/yyyy)

Last Name

Office Use Only

Date of Birth (mm/dd/yyyy)

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.

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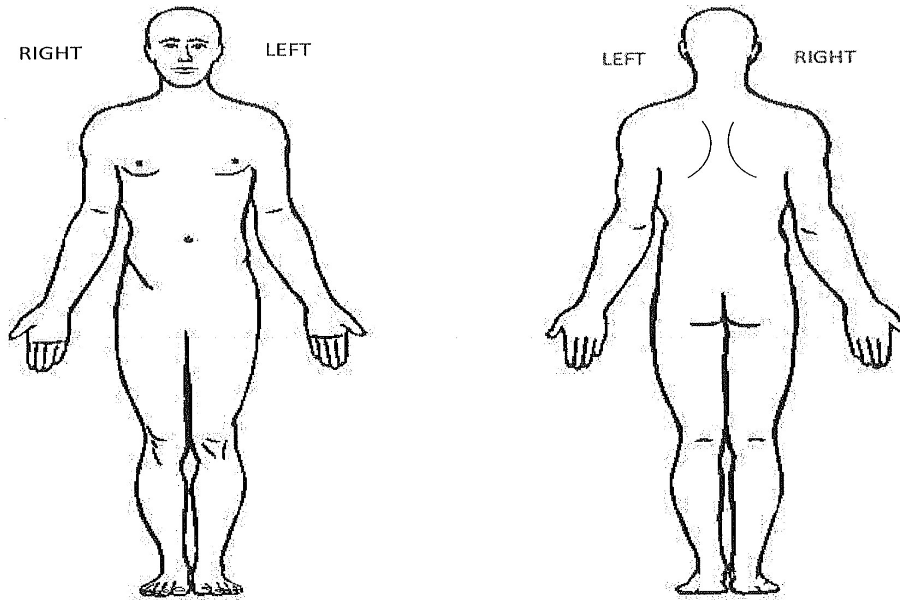
References:
Fairbank JC, Pynsent PB. "The Oswestry Disability Index" Spine 2000; 25(22): 2940-2952
Fairbank JC, Couper J, Davies JB. "The Oswestry Low Back Pain Questionnaire" Physiotherapy 1980: 66: 271-273

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:

Describe your pain:
Aching
Burning
Deep, Diffuse
Discomforting
Dull
Electrical
Localized
Piercing, Sharp
Shooting
Stabbing
Superficial
Throbbing

Timing of your pain:
Continuous and Constant
Continuous, but variable intensities
Intermittent
Progressive
Variable
Daily

Do you have these symptoms:
Numbness
Tingling
Weakness
Pain with coughing or having a BM
Loss of bowel or bladder control

Aggravated by:
Any activity
Stairs
Daily activities
Driving
Exercise
1st steps in the morning
Leaning back
Leaning forward
Physical activity
Sitting
Standing
Walking

Relieved by:
Brace
Heat
Ice
Injections
Leaning back
Leaning forward
Lying Down
Medications
Procedures
Sitting
Standing
Walking

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:

- o No o Yes Fever
- o No o Yes Weight Gain
- o No o Yes Weight Loss
- o No o Yes Other:____________

Head, Eyes, Ears, Nose & Throat:

- o No o Yes Ear Drainage
- o No o Yes Nasal Drainage
- o No o Yes Sinus Pressure
- o No o Yes Sore Throat
- o No o Yes Other:_____________

Respiratory:

- o No o Yes Chronic Cough
- o No o Yes Cough
- o No o Yes Known TB Exposure
- o No o Yes Shortness of Breath
- o No o Yes Wheezing
- o No o Yes Other:_____________

Cardiovascular:

- o No o Yes Chest Pain
- o No o Yes Swelling
- o No o Yes Palpitations
- o No o Yes Other:_____________

Gastrointestinal:

- o No o Yes Constipation
- o No o Yes Diarrhea
- o No o Yes Nausea
- o No o Yes Vomiting
- o No o Yes Other:_____________

Genitourinary:

- o No o Yes Painful Urination
- o No o Yes Blood in Urine
- o No o Yes Urinary Retention
- o No o Yes Other:____________

Reproductive:

- o No o Yes Erectile Dysfunction
- o No o Yes Other:____________

Integumentary:

- o No o Yes Brittle Hair
- o No o Yes Brittle Nails
- o No o Yes Hair Loss
- o No o Yes Itching
- o No o Yes Rash
- o No o Yes Other:____________

Neurological:

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

Psychiatric:

- o No o Yes Anxiety
- o No o Yes Depression
- o No o Yes Insomnia
- o No o Yes Other:____________

Musculoskeletal:

- o No o Yes Back Pain
- o No o Yes Joint Pain
- o No o Yes Joint Swelling
- o No o Yes Muscle Weakness
- o No o Yes Neck Pain
- o No o Yes Other:____________

Hematologic/Lymphatic:

- o No o Yes Easy Bleeding
- o No o Yes Easy Bruising
- o No o Yes Other:____________

Southern Pain AND Neurological

Paul J. Hubbell, III, MD
Donald E. Richardson, MD

Melanie Mire, PA-C
Brooke Vincent, PA-C

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		
Do YOU have a history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Do you have a FAMILY history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Are you between 16-45 years old?	YES	NO
Were you sexually abused as a child?	YES	NO
Have you ever been diagnosed with any of the following mental health conditions?		
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:____

7/28/2020