Oswestry Low Back Pain Disability Questionnaire

Sources: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. *Spine*, 25(22):2940-2953.

Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. *Physical Therapy* 2002;82:8-24.

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the 'gold standard' of low back functional outcome tools [1].

Scoring instructions

For each section the total possible score is 5: if the first statement is marked the section score = 0; if the last statement is marked, it = 5. If all 10 sections are completed the score is calculated as follows:

Example: 16 (total scored)

50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)

45 (total possible score) x 100 = 35.5%

Minimum detectable change (90% confidence): 10% points (change of less than this may be attributable to error in the measurement)

Interpretation of scores

0% to 20%: minimal disability:	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.
21%-40%: moderate disability:	The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.
41%-60%: severe disability:	Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.
61%-80%: crippled:	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
81%-100%:	These patients are either bed-bound or exaggerating their symptoms.

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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 placed eg. 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 walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me 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 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 30 minutes
- ☐ 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 sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours 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 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 eg, sport
- ☐ 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 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me 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

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

(Date and Score)

Activity	Initial					
1.						
2.						
3.						
4.						
5.						
Additional						
Additional						

Total score = sum of the activity scores/number of activities
Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

SF-36 QUESTIONNAIRE

Name:_____ **Ref. Dr:**_____ **Date:** _____

ID#: _____ **Age:** _____ **Gender: M / F**

Please answer the 36 questions of the **Health Survey** completely, honestly, and without interruptions.

GENERAL HEALTH:
In general, would you say your health is:

Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago
Somewhat better now than one year ago
About the same
Somewhat worse now than one year ago
Much worse than one year ago

LIMITATIONS OF ACTIVITIES:
The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
Yes, Limited a lot Yes, Limited a Little No, Not Limited at all

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Lifting or carrying groceries
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Climbing several flights of stairs
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Climbing one flight of stairs
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Bending, kneeling, or stooping
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Walking more than a mile
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Walking several blocks
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Walking one block
Yes, Limited a Lot Yes, Limited a Little No, Not Limited at all

Bathing or dressing yourself

Yes, Limited a Lot | Yes, Limited a Little | No, Not Limited at all

PHYSICAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities

Yes | No

Accomplished less than you would like

Yes | No

Were limited in the kind of work or other activities

Yes | No

Had difficulty performing the work or other activities (for example, it took extra effort)

Yes | No

EMOTIONAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities

Yes | No

Accomplished less than you would like

Yes | No

Didn't do work or other activities as carefully as usual

Yes | No

SOCIAL ACTIVITIES:

Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all | Slightly | Moderately | Severe | Very Severe

PAIN:

How much bodily pain have you had during the past 4 weeks?

None | Very Mild | Mild | Moderate | Severe | Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all | A little bit | Moderately | Quite a bit | Extremely

ENERGY AND EMOTIONS:
These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

Did you feel full of pep?
- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Have you been a very nervous person?
- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Have you felt so down in the dumps that nothing could cheer you up?
- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Have you felt calm and peaceful?
- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Did you have a lot of energy?
- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Have you felt downhearted and blue?

- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Did you feel worn out?

- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Have you been a happy person?

- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

Did you feel tired?

- All of the time
- Most of the time
- A good Bit of the Time
- Some of the time
- A little bit of the time
- None of the Time

SOCIAL ACTIVITIES:

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little bit of the time
- None of the Time

GENERAL HEALTH:
How true or false is each of the following statements for you?

I seem to get sick a little easier than other people

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

I am as healthy as anybody I know

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

I expect my health to get worse

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

My health is excellent

Definitely true | Mostly true | Don't know | Mostly false | Definitely false