Physical Therapy
HUNTSVILLE
Pool & Land
THERAPY Inc.
with a Personal Touch

3303 WESTMILL DRIVE
HUNTSVILLE, AL. 35805
(256) 536-4777 Fax:(256) 539-0105

MEDICAL HISTORY

NAME:_____DOB:_____AGE:_____DATE:_____

HOME PHONE:_____WORK PHONE:_____

ADDRESS:_____

CITY/STATE:_____ZIP:_____

E-mail:_____

Have you previously received services from this facility?_____yes_____no

Have you ever or are you presently being treated for any of the following:

Heart trouble	____yes____no	Cancer	____yes____no
High blood pressure	____yes____no	Pacemaker	____yes____no
Diabetes	____yes____no	Metal Implants	____yes____no
Pregnancy	____yes____no	Allergies	____yes____no
Surgeries	____yes____no	Other	____yes____no
Stroke	____yes____no		

If so,What/when ?_____

_____

Have you been hospitalized for the present problem? ____yes____no
Have you had surgery for the present problem? ____yes____no
Have you received treatment for the present problem? ____yes____no

If so, what kind of treatment and when:_____

_____

Are you on any medication? ___yes___no if so, what TYPE_____

_____

Have you ever had any of the following and when:

____EMG ____X-RAY
____CAT SCAN ____MRI
____MYELOGRAM

I believe the above to be correct to the best of my knowledge.

PATIENT SIGNATURE:_____

Huntsville Pool and Land Therapy, Inc.

Welcome To Our Office

Today's Date _____

INFORMATION (PLEASE PRINT)

PATIENT INFORMATION

NAME (LAST) (FIRST) (INITIAL)	SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER / /
ADDRESS (NO) (STREET OR RR) (CITY) (STATE) (ZIP)		HOME PHONE ( ) -	WORK PHONE ( )
PATIENT OR PARENT'S EMPLOYER	OCCUPATION	EMPLOYER ADDRESS	MARITAL STATUS SIN☐ MAR☐ DIV☐ WID☐
STUDENT ☐ PART TIME	FULL TIME ☐	SPECIFY SCHOOL:	
SPOUSE NAME	SPOUSE'S EMPLOYER	OCCUPATION	WORK PHONE ( ) -
RESPONSIBLE PARTY (If different from patient) (LAST) (FIRST) (INITIAL)		PATIENT RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	
RESPONSIBLE PARTY (Address) (NO.) (STREET OR RR#) (CITY) (STATE) (ZIP)			
NAME OF REFERRING DOCTOR		PHONE ( ) -	
NAME OF EMERGENCY CONTACT	(RELATION)	PHONE ( ) -	
TYPE OF INJURY/AILMENT:	Work Related ☐ Auto Related ☐ Other Accident ☐	School Sports ☐ Recreational Sports ☐ Non-Accident ☐	

GUARANTOR INFORMATION

The guarantor is the holder of the health insurance policy, or if there is no health insurance, the person responsible for the bill

PRIMARY INSURANCE COVERAGE

INSURANCE CO. NAME & ADDRESS			EMPLOYER (FOR WORKERS COMP)
SUBSCRIBER (LAST) (FIRST) (INITIAL)		DATE OF BIRTH / /	SOCIAL SECURITY NO. / /
POLICY ID	GROUP #	EFFECTIVE DATE / /	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COVERAGE

SUBSCRIBER (LAST) (FIRST) (INITIAL)		DATE OF BIRTH / /	SOCIAL SECURITY NO. / /
POLICY ID	EFFECTIVE DATE / /	RELATIONSHIP TO PATIENT	
INSURANCE CO. NAME & ADDRESS		EMPLOYER	

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND AUTHORIZATION FOR TREATMENT

Please read the following and sign in the space provided:

I understand that all fees or charges as a result of my visit are payable at the time the professional services are given. I authorize my insurance carrier, if applicable, to pay for these services for me. I agree to pay for charges not covered by insurance when they are billed to me. I authorize *Huntsville Pool and Land Therapy, Inc.*, to release to my medical insurance company any information about my care here should they request that information.

_____ _____

Signature of Patient Signature of Responsible Party (If different)

HUNTSVILLE POOL & LAND Therapy
Financial and Insurance Policy

Thank you for choosing Huntsville Pool & Land Therapy as your health care provider. We are committed to your being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial and Insurance Policy we require that you read, agree and sign prior to your treatment:

1. We are anxious to help you receive your maximum allowable benefits from your medical insurance and as a courtesy to you we will file claims with your insurance company to help you obtain reimbursement for services rendered. In order to do so we must have the Patient Information sheet COMPLETELY filled out.

2. It is our policy to collect payment for physical therapy treatment at the time services are rendered. For patients who have insurance coverage we will accept the appropriate copayment at the time services are rendered. For your convenience we accept cash, check, Master Card or Visa. For most insurance companies, we are able to immediately check on your deductible. We file our claims daily and we anticipate that your insurance will be taking deductible out on your Explanation of Benefits coming to us, therefore we expect to collect this at the time services are rendered. If the deductible has been met, when the EOB does come in we will apply that $$ toward your copay and then we will reimburse any $$ due.

3. We are currently a PPT (Preferred Physical Therapist) for BCBS, a Participating Provider for Medicare and have various other insurance company contracts. **After your deductible is met**, if we are providing services under a contracted insurance, they should pay according to the agreed fee schedule. As services are rendered you may still owe a copay for each visit. There are only a few companies that no copay is required. We will notify you when you have reached your out of pocket max and your insurance is paying 100%. If you have a secondary insurance we will file it for you, however please be aware that you may still have a copay to fully cover the charges.

4. Not all services are a "covered" or "eligible" benefit in all insurance contracts. We do not always know which are and which are not. In order to be reimbursed for services, they do require that you sign a notification that some services may be "non-covered". This will be your sign-in sheet when you come in for each therapy session. Additionally, each insurance company determines its own fee schedule. Please be aware that your carrier may "disallow," "exclude" or have "non-covered" charges due to their particular fee schedule. You should contact your insurance company if you wish to determine or appeal any of these benefits/charges. Should you have any dispute contact your insurance commissioner, Mr. David Parsons, P.O. Box 330351, Montgomery, AL 36130.

5. $30: for broken appointments without 24 hours notice.
   $50: for no show
   $60: for returned checks

If you do not schedule or do not attend scheduled appointments for 2 weeks without contacting us or w/o prior notice, you will be discharged. 256-536-4777

1.5% service fee: Upon completion of your insurance payments any balance older than 45 days (without further arrangements) is subject to a 1.5% service fee being added to your remaining balance per month and is considered delinquent. Delinquent accounts will be subject to be turned over for collection.

6. The patient and/or the Responsible Party, if any, hereby acknowledge and agree that they are financially responsible to Huntsville Pool & Land Therapy even though there may be insurance or other third party coverage, and agree that failure to make payment when requested is the basis for legal action and agree to pay any and all costs of collection, including a reasonable attorney's fee

7. We realize that medical care can be costly and financial problems may arise periodically. If such problems do occur we expect you to contact us promptly for assistance in management of your account. You may contact us between the hours of 8:00 am and 5:00 pm Monday through Friday, at
(256) 536-4777.

I have read the Financial and Insurance Policy and understand and agree that (regardless of my insurance status), I (and the Responsible Party, if any) am ultimately responsible for the balance on my account for any Physical Therapy services rendered and related charges.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **please** do not hesitate to ask us. We are here to help you and are devoted to providing you with the best possible care. We hope your association with Huntsville Pool & Therapy will be beneficial and pleasant!

_____
Date

_____ _____
Signature of Patient **Signature of Responsible Party**

HUNTSVILLE POOL & LAND THERAPY
WAIVER FOR MASSAGE, WATSU AND INDEPENDENT USE OF THE POOL

I am willingly participating at Huntsville Pool & Land Therapy for massage, watsu or independent use of the pool.

I realize that massage and Watsu are not exact science and no guarantee has been made to me as to the result of this bodywork by any Watsu practitioner, massage therapist or representative of Huntsville Pool & Land Therapy. I understand that this bodywork should not be construed as a substitute for medical examination, diagnosis or treatment that I should see a physician or other qualified medical specialist.

Huntsville Pool & Land Therapy will allow patients or those who have been through physical treatment with us to use the pool independently during regular hours of operation, 8:00 am – 5:00 pm daily.

I will not hold Huntsville Pool & Land Therapy or any representative thereof responsible for any injury of accident on the premises that may occur during independent use of the pool, massage or Watsu.

I also understand Huntsville Pool & Land Therapy is not responsible for valuables and / or personal property brought to the facility.

_____ _____

Signature **Date**

If you want to exercise any of these rights, please contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you) and returned to the attention of our Privacy Officer at the address below.

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 3303 Westmill Dr.
Huntsville, Al 35805

Attn: Privacy Officer

Telephone: (256) 536-4777
Fax: (256) 539-0105

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services a 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is April 14, 2003

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)

To be completed by Huntsville Pool & Land Therapy, Inc.:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):_____

_____

_____

_____ _____
Signature of Huntsville Pool & Land Therapy Representative Date

PRIVACY NOTICE

HUNTSVILLE POOL & LAND THERAPY INC.

PATIENT CONSENT/AUTHORIZATION

PHOTOGRAPHY/VIDEOTAPING/OTHER IMAGING/ FOR TREATMENT, EDUCATION, PURPOSES

Patient's Name: _____

Address: _____

Phone Number: _____

I hereby give my consent to have photographs, videotaped images, other images, made of my family member or myself for the following purposes:

- ☐ Educational Purposes

_____

Signature of Patient or Legal Representative/Relationship Date

_____

Witness Date

CARE CONNECTIONS

PATIENT WORKSHEET

NAME _____ DATE _____

TIME _____ AM/PM ☐ Initial Visit ☐ Discharge Visit

PROBLEM AREA *(Please check one)*:

☐ Upper Extremity (A,D) ☐ Lower Extremity (B,F) ☐ Cervical/Thoracic (C,D) ☐ Lumbar (D,F) ☐ TMJ (C,E)

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING

☐ Symptoms do not prevent me walking any distance.
☐ Symptoms prevent me walking more than 1 mile.
☐ Symptoms prevent me walking more than 1/2 mile.
☐ Symptoms prevent me walking more than 1/4 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.

WORK

(Applies to work in home and outside)

☐ 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 (only light duty).
☐ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

☐ I can manage all personal care without symptoms.
☐ I can manage all personal care with some increased symptoms.
☐ Personal care requires slow, concise movements due to increased symptoms.
☐ I need help to manage some personal care.
☐ I need help to manage all personal care.
☐ I cannot manage any personal care.

SLEEPING

☐ I have no trouble sleeping.
☐ My sleep is mildly disturbed (less than 1 hr. sleepless).
☐ My sleep is mildly disturbed (1–2 hrs. sleepless).
☐ My sleep is moderately disturbed (2–3 hrs. sleepless).
☐ My sleep is greatly disturbed (3–5 hrs. sleepless).
☐ My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

☐ I am able to engage in all my recreational/sports activities without increased symptoms.
☐ I am able to engage in all my recreational/sports activities with some increased symptoms.
☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
☐ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
☐ I can hardly do any recreational/sports activities because of increased symptoms.
☐ I cannot do any recreational/sports activities at all.

ACUITY *(Answer on initial visit.)*

How many days ago did onset/injury occur? _____days

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

■ A. UPPER EXTREMITY

CARRYING

☐ I can carry heavy loads without increased symptoms.
☐ I can carry heavy loads with some increased symptoms.
☐ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
☐ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
☐ I can carry very light weights with some increased symptoms.
☐ I cannot lift or carry anything at all.

DRESSING

☐ I can put on a shirt or blouse without symptoms.
☐ I can put on a shirt or blouse with some increased symptoms.
☐ It is painful to put on a shirt or blouse and I am slow and careful.
☐ I need some help but I manage most of my shirt or blouse dressing.
☐ I need help in most aspects of putting on my shirt or blouse.
☐ I cannot put on a shirt or blouse at all.

REACHING

☐ I can reach to a high shelf to place an empty cup without increased symptoms.
☐ I can reach to a high shelf to place an empty cup with some increased symptoms.
☐ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
☐ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
☐ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
☐ I cannot reach my hand above waist level without increased symptoms.

■ B. LOWER EXTREMITY

STAIRS

☐ I can walk stairs comfortably without a rail.
☐ I can walk stairs comfortably, but with a crutch, cane, or rail.
☐ I can walk more than 1 flight of stairs, but with increased symptoms.
☐ I can walk less than 1 flight of stairs.
☐ I can manage only a single step or curb.
☐ I am unable to manage even a step or curb.

UNEVEN GROUND

☐ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
☐ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
☐ I have to walk very carefully on uneven ground without using a cane or crutches.
☐ I have to walk very carefully on uneven ground even when using a cane or crutches.
☐ I have to walk very carefully on uneven ground and require physical assistance to manage it.
☐ I am unable to walk on uneven ground.

OVER →

C. CERVICAL/TMJ

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.

HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come less than 3 per week.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come 4 or more per week.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

READING

- ☐ I can read as much as I want without increased symptoms.
- ☐ I can read as much as I want with slight symptoms.
- ☐ I can read as much as I want with moderate symptoms.
- ☐ I cannot read as much as I want because of moderate symptoms.
- ☐ I can hardly read at all because of severe symptoms.
- ☐ I cannot read at all.

D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING

- ☐ I can drive my car or travel without any extra symptoms.
- ☐ I can drive my car or travel as long as I want with slight symptoms.
- ☐ I can drive my car or travel as long as I want with moderate symptoms.
- ☐ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ☐ I can hardly drive at all or travel because of severe symptoms.
- ☐ I cannot drive my car or travel at all.

LIFTING

- ☐ I can lift heavy weights without extra symptoms.
- ☐ I can lift heavy weights but it gives extra symptoms.
- ☐ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ☐ My symptoms prevent me from lifting heavy weights but I 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.

E. TMJ

TALKING

- ☐ I can talk without any increased symptoms.
- ☐ I can talk as long as I want with slight symptoms in my jaws.
- ☐ I can talk as long as I want with moderate symptoms in my jaws.
- ☐ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ☐ I can hardly talk at all because of severe symptoms in my jaws.
- ☐ I cannot talk at all.

EATING

- ☐ I can eat whatever I want without symptoms.
- ☐ I can eat whatever I want but it gives extra symptoms.
- ☐ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ☐ Symptoms prevent me from chewing anything other than soft foods.
- ☐ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- ☐ I cannot chew at all and maintain a liquid diet.

F. LUMBAR*/LOWER EXTREMITY

STANDING

- ☐ I can stand as long as I want without increased symptoms.
- ☐ I can stand as long as I want, but it gives me extra symptoms.
- ☐ Symptoms prevent me from standing for more than 1 hour.
- ☐ Symptoms prevent me from standing for more than 30 minutes.
- ☐ Symptoms prevent me from standing for more than 10 minutes.
- ☐ Symptoms prevent me from standing at all.

SQUATTING

- ☐ I can squat fully without the use of my arms for support.
- ☐ I can squat fully, but with symptoms or using my arms for support.
- ☐ I can squat 3/4 of my normal depth, but less than fully.
- ☐ I can squat 1/2 of my normal depth, but less than 3/4.
- ☐ I can squat 1/4 of my normal depth, but less than 1/2.
- ☐ I am unable to squat any distance due to symptoms.

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.
- ☐ My symptoms prevent me sitting more than 1 hour.
- ☐ My symptoms prevent me sitting more than 1/2 hour.
- ☐ My symptoms prevent me sitting more than 10 minutes.
- ☐ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

PAIN INDEX

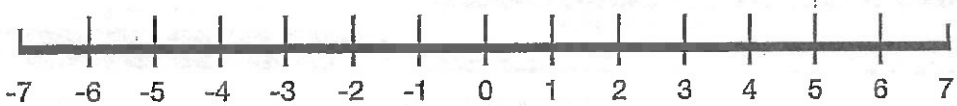
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)



WORK STATUS *(check most appropriate)*

1. ☐ No lost work time
2. ☐ Return to work without restriction
3. ☐ Return to work with modification
4. ☐ Have not returned to work
5. ☐ Not employed outside the home

Work days lost due to condition:_____days

I am aware that the information gather[illegible]'s form may be used anonymously for research or p[illegible]ion. Please initial: _____

OPTIMAL INSTRUMENT

Name: Date:

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 13 2. 8 3. 14*)

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. ____

over →

Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	**Fully confident in my ability to perform**	**Very confident**	**Moderate confidence**	**Some confidence**	**Not confident in my ability to perform**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

Name: _____ Date: _____

Modified Oswestry

How long have you had back pain?___Years ___Months ___Weeks How long have you had leg pain?____Years ___Months ____Weeks

Please read: 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 the *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. 0
- __ The pain is very mild at the moment. 1
- __ The pain is moderate at the moment. 2
- __ The pain is fairly severe at the moment. 3
- __ The pain is very severe at the moment. 4
- __ The pain is the worst imaginable at the moment. 5

Section 2 – Personal Care (Washing, Dressing, etc.)
- __ I can take care of myself normally without causing increased pain. 0
- __ I can take care of myself normally, but it increases pain. 1
- __ It is painful to take care of myself, and I am slow and careful. 2
- __ I need help, but I am able to manage most of my personal care. 3
- __ I need help every day in most aspects of my care. 4
- __ I do not get dressed, wash with difficulty, and stay in bed. 6

Section 3 – Lifting
- __ I can lift heavy weights without increased pain. 0
- __ I can lift heavy weights, but it causes increased pain. 1
- __ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g. on a table). 2
- __ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. 3
- __ I can lift only very light weights. 4
- __ I cannot lift or carry anything at all. 5

Section 4 – Walking
- __ Pain does not prevent me walking any distance. 0
- __ Pain prevents me walking more than 1 mile. 1
- __ Pain prevent me walking more than ½ mile. 2
- __ Pain prevents me walking more than ¼ mile. 3
- __ I can only walk with crutches or a cane. 4
- __ I am in bed most of the time and have to crawl to the toilet. 5

Section 5 – Sitting
- __ I can sit in any chair as long as I like. 0
- __ I can only sit in my favorite chair as long as I like. 1
- __ Pain prevents me from sitting more than 1 hour. 2
- __ Pain prevents me sitting more than ½ hour. 3
- __ Pain prevents me from sitting more than 10 minutes. 4
- __ Pain prevents me from sitting at all. 5

Section 6 – Standing
- __ I can stand as long as I want without increased pain. 0
- __ I can stand as long as I want, but it increases my pain. 1
- __ Pain prevents me from standing for more than 1 hour. 2
- __ Pain prevents me from standing for more than ½ hour. 3
- __ Pain prevents me from standing for more than 10 minutes. 4
- __ Pain prevent me from standing at all. 5

Section 7 – Sleeping
- __ Pain does not prevent me from sleeping well. 0
- __ I can sleep well only by using pain medication. 1
- __ Even when I take pain medication, I sleep less than six hours. 2
- __ Even when I take pain medication, I sleep less than four hours 3
- __ Even when I take pain medication, I sleep less than two hours 4
- __ Pain prevents me from sleeping at all. 5

Section 8 – Social Life
- __ My social life is normal and does not increase my pain. 0
- __ My social life is normal, but it increases my level of pain. 1
- __ Pain prevents me from participating in more energetic activities (e.g. sports, dancing) 2
- __ Pain prevents me from going out very often. 3
- __ Pain has restricted my social life to my home. 4
- __ I have hardly any social life because of pain. 5

Section 9 – Traveling
- __ I can travel anywhere without increased pain. 0
- __ I can travel anywhere, but it increases my pain. 1
- __ My pain restricts my travel to under two hours. 2
- __ My pain restricts my travel to under one hour. 3
- __ My pain restricts me to short necessary journeys under 30 minutes. 4
- __ My pain prevents all travel except for visits to the physician/therapist or hospital. 5

Section 10-Employment/Homemaking
- __ My normal homemaking/job activities do not cause pain. 0
- __ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. 1
- __ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming). 2
- __ Pain prevents me from doing anything but light duties. 3
- __ Pain prevents me from doing even light duties. 4
- __ Pain prevents me from performing any job or homemaking chores. 5

Fairbanks JCT, Pynsent, PB. The Oswestry Disability Index. *Spine*. 25(22): 2000. 2940-2953
Fritz JM, Irrgang. A Comparison of a Modified Oswestry Low Back Pain Di
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Modified Oswestry[64]

Score x 2 = Percent Score

4-6 pts -

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