OSWESTRY DISABILITY QUESTIONNAIRE

Name:
Date: (Month/ dd/ yyyy)

This is designed to give the doctor information as to how your back or leg pain has affected your ability to manage everyday life.

Please mark **one box** in each section which **most closely describes your current condition today**.

PAIN INTENSITY

- ☐ I can tolerate my pain without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on my pain and I do not use them

PERSONAL CARE (e.g. Washing, Dressing)

- ☐ 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

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 i.e. on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking > 2 km
- ☐ Pain prevents me walking > 1 km
- ☐ Pain prevents me walking > 100 m
- ☐ I can only walk using a cane or crutches
- ☐ I am mostly in bed and have to crawl to the toilet

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
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

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 > 1 hour
- ☐ Pain prevents me from standing > 30 minutes
- ☐ Pain prevents me from standing for > 10 minutes
- ☐ Pain prevents me from standing at all

SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have < 6 hours sleep
- ☐ Even when I take medication, I have < 4 hours sleep
- ☐ Even when I take medication, I have < 2 hours sleep
- ☐ Pain prevents me from sleeping at all

SEX LIFE ☐ **(Not 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

SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases degree of pain
- ☐ Pain has no significant effect on my social life apart from
- ☐ 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

TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 min
- ☐ Pain prevents me from travelling except to get treatments

SCREENING FOR GAD-7

Name: _____

Date (Month/dd/yyyy): _____

Over the last 2 weeks, please answer how often have you been bothered by any of the following problems by marking an X:

PROBLEMS	Not at all (0)	Several Days (1)	More than ½ the days (2)	Nearly Everyday (3)
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

_____

If you have marked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PCS Questionnaire

Name: _____

Date (Month/dd/yyyy): _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Using the scale, please indicate the degree which you have these thoughts and feelings when you are experiencing pain.

When I'm in pain …	Not at All (1)	To a Slight Degree (2)	To a Moderate Degree (3)	To a Great Degree (4)	All the Time (5)
I worry all the time about whether the pain will end.	☐	☐	☐	☐	☐
I feel I can't go on.	☐	☐	☐	☐	☐
It's terrible and I think it's never going to get any better.	☐	☐	☐	☐	☐
It's awful and I feel that it overwhelms me.	☐	☐	☐	☐	☐
I feel I can't stand it anymore.	☐	☐	☐	☐	☐
I become afraid that the pain will get worse.	☐	☐	☐	☐	☐
I keep thinking of other painful events.	☐	☐	☐	☐	☐
I anxiously want the pain to go away.	☐	☐	☐	☐	☐
I can't seem to keep it out of my mind.	☐	☐	☐	☐	☐
I keep thinking about how much it hurts.	☐	☐	☐	☐	☐
I keep thinking about how badly I want the pain to stop	☐	☐	☐	☐	☐
There's nothing I can do to reduce the intensity of the pain.	☐	☐	☐	☐	☐
I wonder whether something serious may happen.	☐	☐	☐	☐	☐

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Sullivan MJL, Bishop SR, Pivik J. The Pain Catastrophizing Scale: Development and validation. Psychol Assess. 1995;7:524–32.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date (Month/dd/yyyy): _____

Over the last 2 weeks, please answer how often have you been bothered by any of the following problems by marking an X:

PROBLEMS	Not at all (0)	Several Days (1)	More than ½ the days (2)	Nearly Everyday (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble following or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed **OR** being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

_____

If you have marked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult