

## **Low Back Pain Assessment Form**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

1. Please select one of the choices below which best describes your back pain. Remember to select only one choice:

- A. This is the first time that I have had my pain and it has been present for less than 2 months.
- B. I have had this pain before and it has gotten better and then has come back within the last 2 months.
- C. I have had my current pain for more than 2 months.

2. Please select one of the choice below which best describes the location of your pain.

- A. My pain is located in my back and/or buttock and does not go into my leg.
- B. My pain is located in my back and/or buttock and goes into my leg (s) occasionally but not everyday,
- C. My pain is mainly located in my back and/or buttock but goes in to my leg (s) for at least part of the day.
- D. My pain is mainly located in mm back and/or buttock but also constantly goes into my leg (s).
- E. My pain is mainly in my leg (s) rather than my back.

3. Please list 3 activities that you would like to be able to do but can't do or that are very difficult for you to do:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

4. The following represents the intensity of your pain. The left end of the line indicates **no pain** while the right end represents the worst **pain** that you can imagine. Please put a slash through the part of the line which best represents your average pain over the last week.

**No Pain** \_\_\_\_\_ **Worst Pain**

5. Please read each word below, and decide whether it describes what your pain has felt last week. If a word doesn't describe your pain, circle 0 (does not apply). If a word does describe your pain, then rate how strong the sensation is from 1 being the mildest to 3 being more severe.

Does Not      Mild      Moderate      Severe  
Apply

	0	1	2	3
1. Throbbing	0	1	2	3
2. Shooting	0	1	2	3
3. Stabbing	0	1	2	3
4. Sharp	0	1	2	3
5. Cramping	0	1	2	3
6. Gnawing	0	1	2	3
7. Hot-burning	0	1	2	3
8. Aching	0	1	2	3
9. Heavy	0	1	2	3
10. Tender	0	1	2	3
11. Splitting	0	1	2	3
12. Tiring-exhausting	0	1	2	3
13. Sickening	0	1	2	3
14. Fearful	0	1	2	3
15. Punishing-cruel	0	1	2	3

**Please complete other side**

# The Oswestry Low Back Pain Disability Questionnaire

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

## INSTRUCTIONS:

This questionnaire has been designed to give the therapist 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** that 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 that most closely describes your problem.

### SECTION 1 – PAIN INTENSITY

- The pain is mild and comes and goes.
- The pain is mild and does not vary.
- The pain is moderate and comes and goes.
- The pain is moderate and does not vary much.
- The pain is severe and comes and goes.
- The pain is severe and does not vary.

### SECTION 2 – PERSONAL CARE

- I do not have to change the way I wash and dress myself to avoid pain.
- I do not normally change the way I wash or dress myself even though it causes pain.
- Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- Because of my pain I am partially unable to wash and dress without help.
- Because of my pain I am completely unable to wash or dress without help.

### SECTION 3 – LIFTING

- I can lift heavy weights without increased pain.
- I can lift heavy weights but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights off floor but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I can not lift or carry anything at all.

### SECTION 4 – WALKING

- I have no pain when walking.
- I have pain when walking, but I can still walk required distances
- Pain prevents me from walking long distances
- Pain prevents me from walking intermediate distances.
- Pain prevents me from walking short distances
- Pain prevents me from walking at all.

### SECTION 5 – SITTING

- Sitting does not cause me any pain.
- I can only sit as long as I like given that I have a choice of seating.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting at all.

### SECTION 6 – STANDING

- I can stand as long as I want without increased pain.
- I can stand as long as I want but my pain increases with time.
- 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.
- I avoid standing because pain increases instantly.

### SECTION 7 – SLEEPING

- I have no pain when in bed.
- I get pain in bed in bed but it doesn't stop me from sleeping.
- Because of my pain, I sleep ¾ of the night.
- Because of my pain, I sleep ½ the night.
- Because of my pain, I sleep ¼ of the night.
- Pain prevents me from sleeping at all.

### SECTION 9 – SOCIAL LIFE

- My social life is normal and does not increase pain.
- My social life is normal but increases the degree of pain.
- Pain stops me from energetic activity.
- Pain has restricts me from going out.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

### SECTION 10 – TRAVELING

- 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 two hours.
- Pain restricts me to journeys of less that one hour.
- Pain restricts me to short journeys under 30 minutes.

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

**Fear Avoidance Beliefs Questionnaire (Physical Activity)**

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activity such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree		Unsure		Completely Agree		
	0	1	2	3	4	5	6
My pain was caused by physical activity.	0	1	2	3	4	5	6
*Physical activity makes my pain worse.	0	1	2	3	4	5	6
*Physical activity might harm my back.	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my back pain worse,	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my back pain worse.	0	1	2	3	4	5	6

**FABQ (PA) score:** \_\_\_\_\_  **Greater than 19**  **Less than 12**

**Fear Avoidance Beliefs Questionnaire (Work)**

The following statements are about how your normal work affects or would affect your back.

*My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
*My work aggravated my pain.	0	1	2	3	4	5	6
I have a compensation for my pain.	0	1	2	3	4	5	6
* My work is too heavy for me.	0	1	2	3	4	5	6
*My work makes or would make my pain worse.	0	1	2	3	4	5	6
*My work might harm my back.	0	1	2	3	4	5	6
*I should not do my regular work with my present pain.	0	1	2	3	4	5	6
I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work.	0	1	2	3	4	5	6

**FABQ (W) score:** \_\_\_\_\_  **Greater than 34**  **Less than 19**