LUMBAR OSWESTRY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your back pain has affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please answer based upon your average pain over the past two weeks **without pain medication**.

SECTION 1-Pain intensity

- 0 I have no pain at this moment
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worst imaginable at the moment.

SECTION 2-Personal Care (washing, dressing, etc)

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally, but it causes extra pain
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help, but manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3- Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor , but I can manage if they are conveniently positioned.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- 4 I can lift only very light weights
- 5 I cannot lift or carry anything at all.

SECTION 4- Walking

- 0 Pain does not prevent me walking any distance.
- 1 Pain prevents me from walking for more than 1 mile.
- 2 Pain prevents me from walking for more than ¼ mile.
- 3 Pain prevents me from walking more than 100 yards
- 4 I can only walk using a stick or crutches.
- 5 I am in bed most of the time and have to crawl to the toilet.

SECTION 5- Sitting

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

Signature:_____

Print Name:_____.

Date: _____

SECTION 6 – Standing

- 0 I can stand as long as I want without extra pain.
- 1 I can stand as long as I want, but it gives me extra pain.
- 2 Pain prevents me from standing more than 1 hour.
- 3 Pain prevents me from standing for more than ½ hour.
- 4 Pain prevents me from standing for more than 10 minutes.
- 5 Pain prevents me from standing at all.

SECTION 7- Sleeping

- 0 My sleep is never disturbed by pain.
- 1 My sleep is occasionally disturbed by pain
- 2 Because of pain I have less than 6 hours sleep.
- 3 Because of pain I have less than 4 hours sleep.
- 4 Because of pain I have less than 2 hours sleep
- 5 Pain prevents me from sleeping at all.

SECTION 8 – Sex Life

- 0 My sex life is normal and causes no extra pain.
- 1 My sex life is normal, but causes some pain.
- 2 My sex life is nearly normal, but is very painful.
- 3 My sex life is severely restricted by pain
- 4 My sex life is nearly absent because of back pain
- 5 I have no sex life because of pain

SECTION 9 – Social Life

- 0 My social life is normal and gives me no extra pain.
- 1 My social life is normal, but increases the degree of pain
- 2 Pain has no effect on my social life apart from limiting my more energetic interests
- 3 Pain has restricted my social life and I do not go out as often.
- 4 Pain has restricted my social life to my home.
- 5 I have no social life because of pain

SECTION 10- Traveling

- 0 I can travel anywhere without extra pain.
- 1 I can travel anywhere, but it gives extra pain.
- 2 Pain is bad, but I manage journeys over two hours.
- 3 Pain restricts me to journeys of less than one hour.
- 4 Pain restricts me to short necessary journeys less than 30 minutes
- 5 Pain prevents me from traveling except to receive treatment.

Score: %_____ **BMI:** _____

DOB: ___/ /___ **Age**:_____

ICD-9: _____ **Diagnosis:** _____

Level of Injection: office use

RATE YOUR PAIN ON THE SCALE OF 1-10 AND PLACE A NUMBER IN EACH OF THE BLANK SPACES:

LOW BACK ____ LEG: L:____ R:____ BUTTOCK: L:_____ R: _____

IF YOU ARE POST-OP: (Please Circle)

1. Overall were you satisfied with your Procedure? **YES NO** 2. Returned to work after procedure? **YES NO**
3. If given the chance would you repeat the same procedure for the same outcome? **YES NO** 4. Retired? **YES NO**

Pre-Op 6 Wks. 3 Mon. 6 Mon. 1 Year 2 Year 3 Year 4 Year 5 Year