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Date of completion
March 16, 2022

Oswestry Low Back Pain Disability Questionnaire

Clinician's name (or ref) ----------

Patient's name (or ref)

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition today.

During the past 4 weeks.....

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 (e.g., Washing, Dressing)

- ◯ I can look after myself normally without causing extra pain
- ◯ I can look after myself normally but it is very painful
- ◯ 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, 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 the weights are conveniently positioned (e.g., 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 only very light weights.
- ◯ I cannot lift or carry anything at all.

Section 4 - Walking

- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ◯ Pain prevents me from walking more than 1/4 mile.
- ◯ Pain prevents me from walking more than 100 yards.
- ◯ I can walk only with crutches or a stick.
- ◯ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ◯ I can sit in any chair as long as I like

Section 6 - Standing

- ◯ I can stand as long as I want without extra pain.
- ◯ I can stand as long as I want but it extra my pain.
- ◯ Pain prevents me from standing for more than 1 hour.
- ◯ Pain prevents me from standing for more than ½ an hour.
- ◯ 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 causes 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 (e.g., sports, dancing).
- ◯ Painhas 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 my pain.

Section 10 - Traveling

- ◯ I can travel anywhere without pain.

◯ I can sit in my favourite chair for as long as I like	◯ I can travel anywhere, but it gives extra pain.
◯ Pain prevents me from sitting for more than 1 hour.	◯ Pain is bad but I mangage journeys of over 2 hours.
◯ Pain prevents me from sitting for more than ½ an hour	◯ Pain restricts me to journeys of less than 1 hour.
◯ Pain prevents me from sitting for more that 10 minutes	◯ Pain restricts me to short necessary journeys under 30 minutes
◯ Pain prevents me from sitting at all.	◯ Pain prevents me from travelling except to recieve treatment

Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? (Please tick the appropriate box.)	◯ Yes ◯ No
.....if yes, please state the type of treatment you have received)	

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The Oswestry Low back pain Score is:

0 %

Reference for Score: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy. 1980 Aug;66(8):271-3. link

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