

Today's date: _____ Pts. name _____ Date of
birth: _____

OSWESTRY FUNCTION TEST

PLEASE CIRCLE ONE ANSWER ONLY

Pain Intensity

1. I can tolerate my pain without having to use pain killers.
2. My pain is bad but I can manage without taking pain killers.
3. Pain killers give me complete relief from my pain.
4. Pain killers give me moderate relief from my pain.
5. Pain killers give me very little relief from my pain.
6. Pain killers have no effect on my pain and I do not use them.

Personal Care

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

Lifting

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

Walking

1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than 1 mile.
3. Pain prevents me from walking more than $\frac{1}{2}$ of a mile.
4. Pain prevents me from walking more than $\frac{1}{4}$ of a mile.
5. I can only walk using a cane or crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Sitting

1. I can sit in any chair as long as I like.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than 1 hour.
4. Pain prevents me from sitting more than $\frac{1}{2}$ of an hour.
5. Pain prevents me from sitting more than 10 minutes.
6. Pain prevents me from sitting at all.

Standing

1. I can stand as long as I want without extra pain.
2. I can stand as long as I want but it gives me extra pain.
3. Pain prevents me from standing for more than 1 hour.
4. Pain prevents me from standing for more than $\frac{1}{2}$ of an hour.
5. Pain prevents me from standing more than 10 minutes.
6. Pain prevents me from standing at all.

Sleeping

1. Pain does not prevent me from sleeping well.
2. I can sleep well only by taking medication for sleep.
3. Even when I take medication, I have less than 6 hours of sleep.
4. Even when I take medication, I have less than 4 hours of sleep.
5. Even when I take medication, I have less than 2 hours of sleep.
6. Pain prevents me from sleeping at all.

Sex Life

1. My sex life is normal and gives me no extra pain.
2. My sex life is normal but causes some extra pain.
3. My sex life is nearly normal but is very painful.
4. My sex life is severely restricted by pain.
5. My sex life is nearly absent because of pain.
6. Pain prevents any sex life at all.

Social Life

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

Traveling

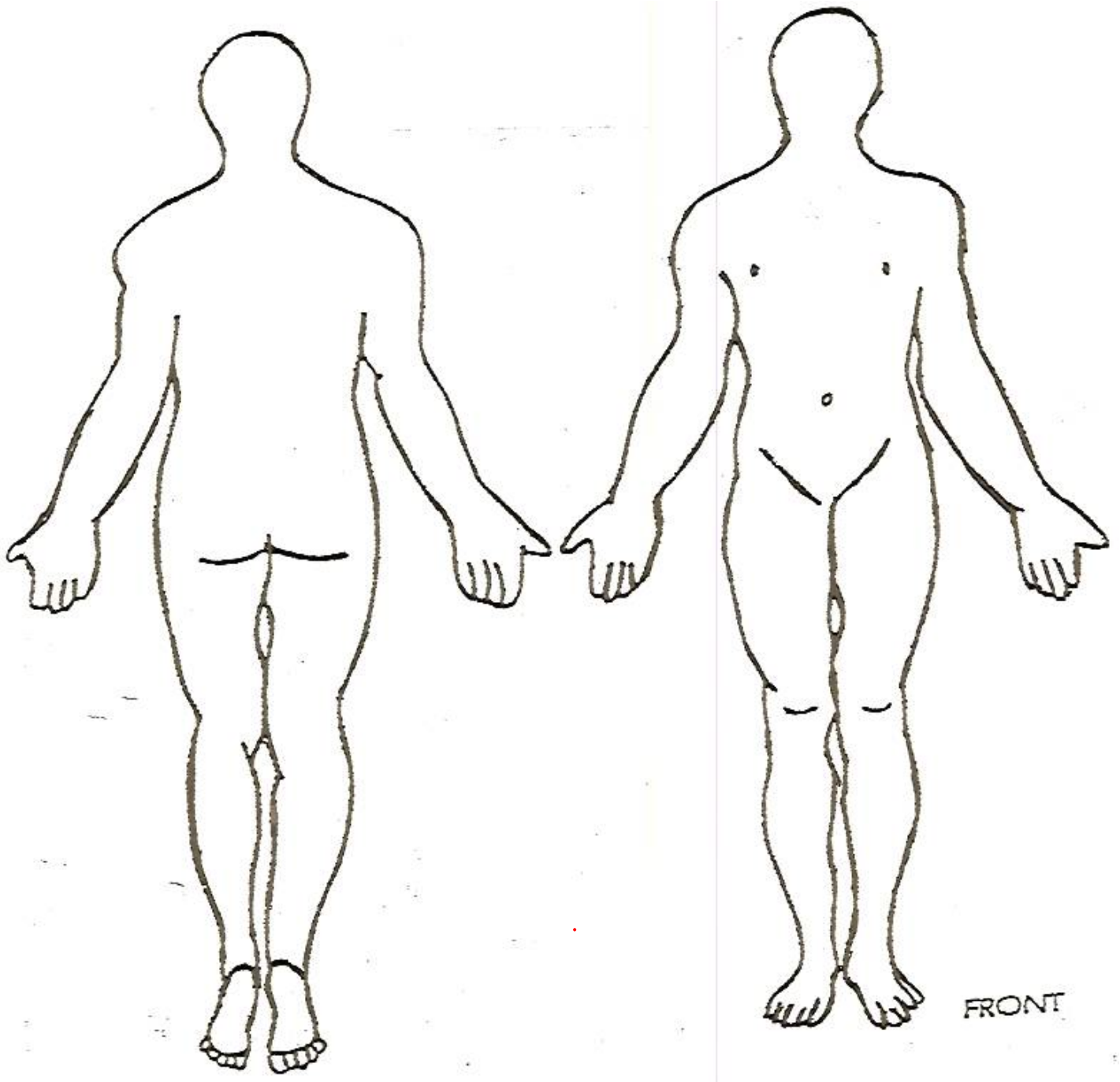
1. I can travel anywhere without extra pain.
2. I can travel anywhere but it gives me extra pain.
3. Pain is bad but I manage journeys over 2 hours.
4. Pain restricts me to journeys of less than 1 hour.
5. Pain restricts me to short necessary journeys of less than $\frac{1}{2}$ of an hour.
6. Pain prevents me from traveling except to the doctor.

TOTAL SCORE _____

Please mark the areas of your body where you feel the described sensation. Please use the appropriate symbol. Please mark the areas of radiation. Please include all affected areas. Just to complete the picture, please draw your face.

NUMBNESS	----	PINS & NEEDLES	0000	BURNING	XXXX	STABING	////
	----		0000		XXXX		////
	----		0000		XXXX		////

Have you had prior back or neck surgery?
() Yes () No



DO YOU HAVE **ANY PROBLEMS** WITH ANY OF THE ITEMS BELOW: (Please answer Yes or No)

NEUROLOGIC

Thinking clearly _____
 Walking _____
 Weakness _____
 Sensory changes _____
 Dizziness _____

UROGENITAL

Incontinence _____
 Retention _____
 Urgency _____
 Urinating frequently _____
 Sexual dysfunction _____
 Sexual disease _____
 Other _____

GASTROINTESTINAL

Constipation _____
 Frequent diarrhea _____
 Other _____

CARDIAC AND PULMONARY

Chest Pain _____
 Palpitations _____
 Shortness of breath _____
 Heart disease _____
 Other _____

MUSCULOSKELETAL

Muscle ache _____
 Pain _____
 Swelling _____
 Limited motion _____

HEENT

Glasses _____
 Visual change _____
 Hearing change _____

CONSTITUTIONAL Weight loss: _____ PSYCHIATRIC Illness: _____ Sleep disturbance: _____

(Review of Systems – 5 items and all other negative → comp)

PLEASE INDICATE BELOW WHICH HAVE BEEN **PAST MEDICAL PROBLEMS** FOR YOU

	YES	NO		YES	NO
Heart Disease			Blood clots in your legs or lungs		
High Blood pressure (Hypertension)			Neurological disease		
Lung disease (see below):			Have you ever had a stroke?		
Bronchitis			Do you have seizures?		
Emphysema			Cancer		
Asthma			Osteoporosis		
Diabetes			Osteoarthritis, degenerative arthritis		
Ulcer or stomach disease			Rheumatoid arthritis		
Kidney or bladder disease			Thyroid disorder		
Liver disease			Other medical problems please specify		
Anemia or any blood disease			(Exam: (18 or more item → comp))		

Have you ever been hospitalized? Yes ___ No ___ Had an operation? Yes ___ No ___

Please list all hospitalizations and operations: _____

