Description: This survey is meant to obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

MODIFIED OSWESTRY DISABILITY SCALE- INITIAL VISIT

1. Pain Intensity

(0) I can tolerate the pain without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor,
(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.

4. Walking

(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

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

6. Standing

(0) I can stand as long as I want without increased pain.
(1) I can stand as long I want, but it increases my pain.
(2) Pain prevents me from standing more than one hour.
(3) Pain prevents me from standing more than ½ hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hours.
(5) Pain prevents me from sleeping at all.

8. Social Life

(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I can hardly have any social life because of my pain.

9. Traveling

(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys under ½ hour.
(5) My pain prevents all travel except for visits to the Physician/therapist or hospital.

10. Employment/Homemaking

(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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Olympic Physical Therapy, LLC

Patient Name:____ **Date:**____________________________

Age:_________ **Height:**__________ **Weight:**_____________

How much pain do you have <u>today?</u> Please circle a number (0= no pain, 10= worst pain)

0 1 2 3 4 5 6 7 8 9 10

What medications are you currently taking? Please include prescription meds, over the counter meds, and supplements with names, dosage, and frequency. **<u>Please list below</u>**:

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Have you had two or more falls in the past year? (Please circle one): **Yes** **No**

Have you had an injury as a result of a fall in the past year? (Please circle one): **Yes** **No**

Who is your primary care physician?____

When is the next time you are seeing a physician?____

Did you have a specific injury or surgery for this problem? Yes No Date(s):____________________

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Have you had any diagnostic tests for this problem? Yes No Date(s):____________________

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Please list any other medical problems you have, or any other surgeries you have had?___________________

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What is your occupation?____

Has your work schedule been modified because of this problem?______________________________________

Are you living alone at this time?____

What goal(s) would you like to accomplish with PT? ____