

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.

Olympic Physical Therapy, LLC

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

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

0 1 2 3 4 5 6 7 8 9 10

Please list below any medications you are currently taking. Please include prescription meds, over the counter meds, and/or supplements with names, dosage, and frequency.

Drug Name	Dosage	Frequency	Drug name	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

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

Have you had two or more falls in the past year? **Yes** **No**

Who is your primary care physician? _____

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

Have you had any diagnostic tests for this problem? **Yes** **No** (If Yes, please list below):

Have you had a specific injury or surgery for this problem? **Yes** **No** (If Yes, please list below):

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

Are you currently employed? **Yes** **No** Job Title? _____

Has your work schedule been modified because of this problem? **Yes** **No**

Are you living alone at this time? **Yes** **No**

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

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