Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much you low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **ONE** circle that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just mark **ONE** circle that most closely describes your problem.

Section 1 - Pain Intensity

O I can tolerate pain without using painkillers.
O The pain is bad but I can manage without taking painkillers.
O Painkillers give me complete relief from pain.
O Painkillers give moderate relief from pain.
O Painkillers give very little relief from pain.
O Painkillers have no effect on the pain and I do not use them.

Section 2 - Personal Care

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

Section 3 - Lifting

O I can lift heavy weights without extra pain.
O I can lift heavy weights but it causes extra pain.
O Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
O Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
O I can only lift light weights at the most
O I cannot lift or carry anything at all.

Section 4 - Walking

O I have no pain walking.
O I have some pain on walking, but I can still walk my required to normal distances.
O Pain prevents me from walking long distances.
O Pain prevents me from walking intermediate distances.
O Pain prevents me from walking short distances.
O Pain prevents me from walking at all.

Section 5 - Sitting

O Sitting does not cause me any pain.
O I can sit as long as I need provided I have my choice of sitting surfaces.
O Pain prevents me from sitting more than 1 hour.
O Pain prevents me from sitting more than 1/2 hour.
O Pain prevents me from sitting more than 10 minutes.
O Pain prevents me from sitting at all.

Section 6 - Standing

O I can stand as long as I want without pain.
O I have some pain while standing, but it does not increase with time.
O I cannot stand for longer than 1 hour without increasing pain.
O I cannot stand for longer than 1/2 hour without increasing pain.
O I cannot stand for longer than 10 minutes without increasing pain.
O I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

O I have no pain while in bed.
O I have pain in bed, but it does not prevent me from sleeping well.
O Because of pain I sleep only 3/4 of normal time.
O Because of pain I sleep only 1/2 of normal time.
O Because of pain I sleep only 1/4 of normal time.
O Pain prevents me from sleeping at all.

Section 8 - Social Life

O My social life is normal and gives me no pain.
O My social life in normal, but increases the degree of pain.
O Pain prevents me from participating in more energetic activities e.g. sports, dancing.
O Pain prevents me from going out very often.
O Pain has restricted my social life to my home.
O I hardly have any social life because of pain.

Section 9 - Traveling

- O I get no pain while traveling.
- O I get some pain while traveling, but none of my usual forms of travel make it any worse.
- O I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- O I get extra pain while traveling that requires me to seek alternative forms of travel.
- O Pain restricts all forms of travel.
- O Pain prevents all forms of travel except that done lying down.

Total: _____

Signature: _____

Section 10 – Employment/Homemaking

- O My normal job/homemaking duties do not cause pain.
- O My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- O I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming.
- O Pain prevents me from doing anything but light duties.
- O Pain prevents me from doing even light duties.
- O Pain prevents me from performing any job or homemaking chore.

Date: _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

UNIVERSITY of MARYLAND
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REHABILITATION

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Therapy Attendance Agreement

Welcome to Outpatient Physical Therapy at University of Maryland Charles Regional Rehabilitation. Our goal is to provide you with the best therapy services to reach your maximum potential and to improve your quality of life. We would like to inform you of our therapy attendance policy to ensure that you are getting the treatment that you need and other patients are not missing out on possible therapy times that they could have received.

Please read through and initial on the line that you have read and understand each statement:

____ CALL TO CANCEL OR RESCHEDULE. If you miss one therapy appointment without calling or cancelling at least 24 hours prior, you will be charged a $25 no show fee.

____ATTEND ALL YOUR APPOINTMENTS. If you miss three (3) consecutive therapy sessions and do not call, you will be discharged from therapy at the discretion of the therapist.

____ BE ON TIME. If you are more than 10 minutes late to a 30 minute appointment, it is up to the treating therapist if you will be seen that day.

____ If you have multiple cancellations, instances of tardiness, or missed appointments, it is up to the discretion of the primary therapist to discharge you from therapy.

All scheduling is on a first come, first served basis. We understand that both your schedule and our schedule can change and we will do our best to accommodate any changes that arise. Please inform us if you would like a copy of this form or if you have any questions about our appointment policy stated above.

Please sign that you understand and agree to the above policy:

_____ (Patient/Guardian) _____ (Date & Time)

_____ (UM CRR Staff member) _____ (Date & Time)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Please answer all questions to the best of your knowledge

Do you have any known allergies (drugs, food, pollens, latex etc): _____

Have you had any falls in the last 12 months (please circle)? **Yes** **No**

How many falls? _____ Did any fall result in injury? **Yes** **No**

Have you had any near falls? **Yes** **No** How many in the last 12 months? _____

How do you learn best (please circle): **Reading** **Demonstration** **Pictures** **Listening**

Do you feel safe in your home (please circle)? **Yes** **No**

Are you being threatened or hurt by someone (please circle)? **Yes** **No**

Over the past 2 weeks, how often have you been bothered by any of the following problems (please circle)?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

What is your preferred language? _____

Which language do you want to use while you are receiving services here? _____

Do you have, or have you had, any of the following?

- ☐ Aids/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, Bronchitis, COPD, or Emphysema
- ☐ Cancer
- ☐ Cardiac History (Angina, Congenital Heart Disorder, Heart Attack, Pace Maker, Defibrillator, Palpitations, Irregular Heartbeat, Other)
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness or Vertigo
- ☐ Edema
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Frequent Cough
- ☐ Gout
- ☐ Headaches or Migraines
- ☐ Hearing Difficulties or Ringing in your ears
- ☐ Hepatitis A, B or C
- ☐ High/Low Blood pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Loss or Cognitive Problems
- ☐ Nausea/Vomiting
- ☐ Orthopedic History
- ☐ Osteoporosis
- ☐ Pain
- ☐ Pregnant or Nursing
- ☐ Recent Weight loss
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Abnormalities
- ☐ Sleeping Difficulties
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vision Problems (Galucoma, Cataracts, Macular Degeneration, etc)
- ☐ Other _____

Comments and details regarding above history (surgeries and medication on next page): _____

Has the patient OR a sick close contact had international travel with in the last 30 days? **Yes** **No**

Where was the travel to and on what dates? _____

Does the patient currently have a fever OR flu-like symptoms? **Yes** **No**

(Symptoms include headache, aches, vomiting, abdominal pain, diarrhea, chills, etc)

University of Maryland
Charles Regional Medical Center
LaPlata, Maryland 20646

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE

PATIENT LABEL

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Major Surgeries	Date	Current Medication	Dosage	Frequency
(Please ask for surgery/medication form if more space is needed)				

Therapist Review – Office Use only

Have you previously participated in physical/occupational/speech therapy? **Yes No**

Have you had therapy services this calendar year? **Yes No**

Were you treated for your current diagnosis or another diagnosis? **Current Different**

Have you had any recent imaging performed (please circle)?

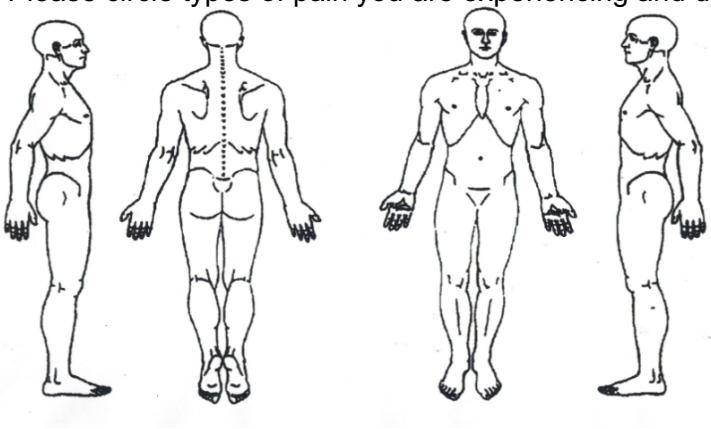
X-ray CT scan MRI EMG Modified Barium Swallow Other

Do you have any restrictions from activity from your doctor? **Yes No**

If yes, please explain: _____

What are your goals for therapy? _____

Please circle types of pain you are experiencing and draw or shade in areas of pain on the diagram:



Aching	**Burning**	**Cramping**
Dull	**Numbness**	**Pins & Needles**
Radiating	**Sharp**	**Shock Like**
Spasm	**Squeezing**	**Stabbing**
Throbbing	**Tightness**	**Tingling**
Tiring	**Other: Please explain**	_____

Advanced Directives: ☐ Durable Power of Attorney ☐ Living Will ☐ Organ Donor ☐ DNR ☐ N/A

Patients Name (Please write legibly): _____

Signature of Patient: _____ Date:_____

Signature of Caregiver (if under 18 or assisting in filling out form): _____

Signature of Therapist: _____ Date:_____

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RS-027 (0816)

PATIENT LABEL

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE