

**FLORIDA ORTHOPAEDIC INSTITUTE  
OSWESTRY PAIN SCALE**

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

How long have you had neck and back pain?	_____ Years	_____ Months	_____ Weeks
How long have you had leg pain?	_____ Years	_____ Months	_____ Weeks
How long have you had arm pain?	_____ Years	_____ Months	_____ Weeks

**PLEASE READ:**

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one statement that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just circle the statement which most closely describes your problem.

**Section 1 – Pain Intensity**

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain, and I do not use them.

**Section 2 – Personal Care (Washing, Dressing, etc.)**

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- 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 they 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 walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk using a stick or crutches.
- 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.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

**Section 6 – Standing**

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

**Section 7 – Sleeping**

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets, I have less than 6 hours sleep.
- Even when I take tablets, I have less than 4 hours sleep.
- Even when I take tablets, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

**Section 8 – Sex Life**

- 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 gives 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. dancing
- Pain has restricted my social life, and I do not go out often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

**Section 10 – Traveling**

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys less than 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

COMMENTS \_\_\_\_\_

**PATIENT PAIN DRAWING**

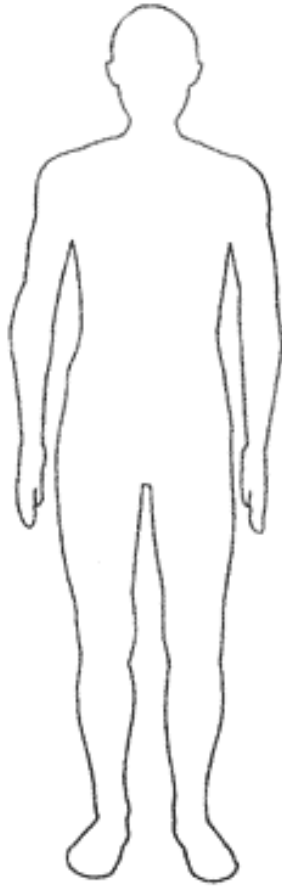
NAME \_\_\_\_\_ DATE \_\_\_\_\_

**WHERE IS YOUR PAIN NOW?**

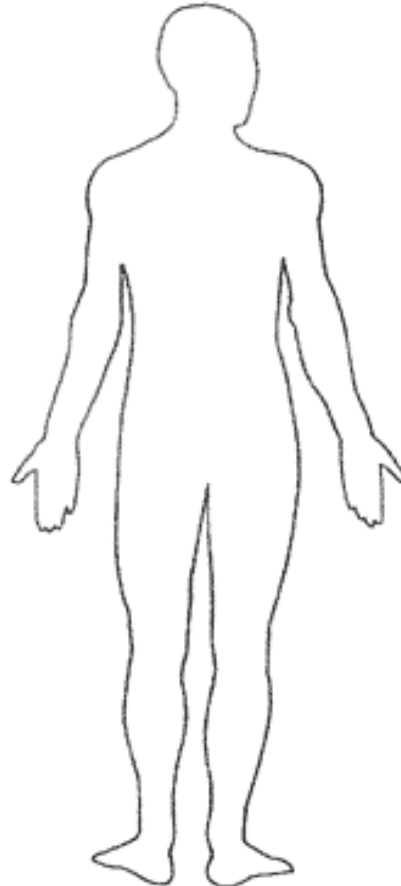
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

- Aching                      Numbness                      Pins and Needles                      Burning                      Stabbing
- ▲▲▲                      ===                      ooo                      \*\*\*                      ///

FRONT VIEW



BACK VIEW



**How bad is your pain now?**

Please mark with an X on the body drawing where the pain is worst now.

Please mark on the line how bad your pain is now:

No pain \_\_\_\_\_ Worst possible pain

Comments:

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**FLORIDA ORTHOPAEDIC INSTITUTE**  
**John M. Small**

**SF-36 Questionnaire**

Instructions: Thank you in advance for taking the time to fill this questionnaire out. This questionnaire is about **YOU** and how **YOU** feel your physical health affects other aspects of your life. There are no right or wrong answers. Please read each question carefully, and answer as honestly as you can. Circle the **ONE** response that **YOU** feel represents **YOUR** feelings.

1. In general, would you say your health is:

- Excellent..... 1
- Very Good..... 2
- Good ..... 3
- Fair..... 4
- Poor..... 5

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than 1 year ago..... 1
- Somewhat better now than 1 year ago..... 2
- About the same as 1 year ago..... 3
- Somewhat worse now than 1 year ago..... 4
- Much worse now than 1 year ago..... 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes Limited a lot	Yes Limited a little	No Not limited at all
a. Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than one mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- a. Cut down the amount of time you spent on work or other activities      1 Yes      2 No
- b. Accomplished less than you would like      1 Yes      2 No
- c. Were limited in the kind of work or other activities      1 Yes      2 No
- d. Had difficulty performing work or other activities (for example, it took extra effort)      1 Yes      2 No

5. During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious?)

- a. Cut down on the amount of time you spent on work or other activities      1 Yes      2 No
- b. Accomplished less than you would like      1 Yes      2 No
- c. Didn't do work or other activities as carefully as usual      1 Yes      2 No

Office Use Only
MR# _____
Type of Visit Pre-Op 6-week 3-month 6-month 12-month 24-month
Other: _____

**FLORIDA ORTHOPAEDIC INSTITUTE**  
**John M. Small**

**SF-36 Questionnaire**

6. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

1 Not at all      2 Slightly      3 Moderately      4 Quite a bit      5 Extremely

7. How much bodily pain have you had during the past 4 weeks?

1 None      2 Very Mild      3 Mild      4 Moderate      5 Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

1 Not at all      2 A little bit      3 Moderately      4 Quite a bit      5 Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling:

How much of the time during the past 4 weeks

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Did you feel full of pep?</u>	1	2	3	4	5
b. <u>Have you been very nervous?</u>	1	2	3	4	5
c. <u>Have you felt down in the dumps?</u>	1	2	3	4	5
d. <u>Have you felt calm and peaceful?</u>	1	2	3	4	5
e. <u>Did you have a lot of energy?</u>	1	2	3	4	5
f. <u>Have you felt downhearted and blue?</u>	1	2	3	4	5
g. <u>Did you feel worn out?</u>	1	2	3	4	5
h. <u>Have you been happy?</u>	1	2	3	4	5
i. <u>Have you felt tired?</u>	1	2	3	4	5

10. During the past 4 weeks, how much of your time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)

1 All of the time      2 Most of the time      3 Some of the time      4 A little of the time      5 None of the time

11. How true or false is each of the following statements for you?

	Definitely True	Mostly true	Don't Know	Mostly False	Definitely False
a. <u>I seem to get sick a little easier than other people</u>	1	2	3	4	5
b. <u>I am as healthy as anybody I know</u>	1	2	3	4	5
c. <u>I expect my health to get worse</u>	1	2	3	4	5
d. <u>My health is excellent</u>	1	2	3	4	5