

Northern California Spine & Rehabilitation Associates, Inc.  
2801 K Street, #410  
Sacramento, CA 95816

### OSWESTRY QUESTIONNAIRE

**INSTRUCTIONS:** This questionnaire has been designed to give us information as to how your back and leg pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section **ONLY ONE** answer that applies to you. We realize you may consider that two of the statements in any one section relate to you. **PLEASE SELECT THE ONE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM.**

Section 1 – Pain Intensity (mark only one)

- 0 I have no pain at this moment
- 1 The pain is very mild at the moment
- 2 The pain is moderate at the moment
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, dressing, etc.) (mark only one)

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

Section 3 – Lifting (mark only one)

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it gives extra pain
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
- 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

Section 4 – Walking (mark only one)

- 0 Pain does not prevent me walking any distance
- 1 Pain prevents me from walking more than 1 mile
- 2 Pain prevents me from walking for more than ¼ mile

- 3 Pain prevents me from walking more than 100 yards
- 4 I can only walk using a stick or crutches
- 5 I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting (mark only one)

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

Section 6 – Standing (mark only one)

- 0 I can stand as long as I want without extra pain
- 1 I can stand as long as I want, but it gives me extra pain
- 2 Pain prevents me from standing more than 1 hour
- 3 Pain prevents me from standing for more than ½ hour
- 4 Pain prevents me from standing for more than 10 minutes
- 5 Pain prevents me from standing at all

Section 7 – Sleeping (mark only one)

- 0 My sleep is never disturbed by pain
- 1 My sleep is occasionally disturbed by pain
- 2 Because of pain, I have less than 6 hours sleep
- 3 Because of pain, I have less than 4 hours sleep
- 4 Because of pain, I have less than 2 hours sleep
- 5 Pain prevents me from sleeping at all

Section 8 – Sex Life (mark only one)

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

Section 9 – Social Life (mark only one)

- 0 My social life is normal and gives me no extra pain

- 1 My social life is normal, but increases the degree of pain
- 2 Pain has not significantly effected my social life apart from limiting my more energetic interests
- 3 Pain has restricted my social life and I do not go out as often
- 4 Pain has restricted my social life to my home
- 5 I have no social life because of pain

Section 10 – Traveling (mark only one)

- 0 I can travel anywhere without extra pain
- 1 I can travel anywhere, but it gives extra pain
- 2 Pain is bad, but I manage journeys over two hours
- 3 Pain restricts my journeys to less than one hour
- 4 Pain restricts me to short, necessary journeys under 30 minutes
- 5 Pain prevents me from traveling except to receive treatment

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Patient Siganture

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Print Name

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Date

NORTHERN CALIFORNIA SPINE CENTER

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Birthplace \_\_\_\_\_

Marital Status: S W M D Occupation \_\_\_\_\_

Medication or Dye Allergies or Sensitivities (Please List)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

OFFICE USE ONLY
T: _____
P: _____
R: _____
B/P: _____
LMP: _____

Have you had recent contact with any communicable diseases? YES NO

Do you now or have you ever taken any of the following:

Isotopes \_\_\_\_\_ YES NO

Steroids \_\_\_\_\_ YES NO

Anti Coagulants (Blood Thinners) \_\_\_\_\_ YES NO

**1. Family History**

	Age	Living/ Health	Age	Deceased/ Cause of Death
Mother				
Father				
Siblings	<b>Sex</b>			

**2. Personal History**

	Age	Sex	Health
Spouse			
Children			

Does anyone in your family have:

Bone or Joint Problems \_\_\_\_\_ YES NO

Rheumatic Disease \_\_\_\_\_ YES NO

Heart Disease \_\_\_\_\_ YES NO

High Blood Pressure \_\_\_\_\_ YES NO  
 Diabetes \_\_\_\_\_ YES NO  
 Cancer \_\_\_\_\_ YES NO  
 Tuberculosis \_\_\_\_\_ YES NO  
 Bleeding Disorder \_\_\_\_\_ YES NO  
 Any Other Diseases \_\_\_\_\_ YES NO

Weight in Lbs: Average \_\_\_\_\_ Maximum \_\_\_\_\_ Minimum \_\_\_\_\_ Present \_\_\_\_\_

How Much gain this year \_\_\_\_\_ How much loss this year \_\_\_\_\_

**3. Past Medical History** (Please check where applicable.)

a. Childhood disease: Measles \_\_\_\_ Mumps \_\_\_\_ Chickenpox \_\_\_\_ Scarlet Fever \_\_\_\_  
 Rheumatic Fever \_\_\_\_ Other \_\_\_\_\_

b. Operations:

Type	Date	Complications

c. Injuries (Broken bones, sprains, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d. Blood Transfusions:

Reason	Date	Complications

e. Habits:

Smoke: YES NO Packs/Day \_\_\_\_\_

Drink YES NO Drinks/Day \_\_\_\_\_

\_\_\_\_\_

f. Recent travel outside of continental United States:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- g. Current Medications and Dosage you are now using (Including birth control pills – If these have been taken within the past two months):

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- h. Immunizations within the past five years:

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- i. Medical doctors previously consulted for present problem:

Name	Address

- j. Other medical doctors consulted in past five years:

Name	Problem:

Family Doctor: \_\_\_\_\_

Review of Systems: Have you ever had (Please check)

1. Skin:

Change in skin texture \_\_\_\_\_ YES NO  
 Chronic skin rash \_\_\_\_\_ YES NO  
 Chronic skin lesion \_\_\_\_\_ YES NO  
 Change in hair texture \_\_\_\_\_ YES NO  
 Difficulty with toe nails \_\_\_\_\_ YES NO  
 Other \_\_\_\_\_ YES NO

2. Head, Eyes, Ears, Nose, Throat:

Recurrent Headaches \_\_\_\_\_ YES NO  
 Difficulty With:  
 a. Vision \_\_\_\_\_ YES NO  
 b. Hearing \_\_\_\_\_ YES NO  
 c. Balance \_\_\_\_\_ YES NO

Dizziness _____	YES	NO
Recurrent Ear Infection _____	YES	NO
Wear Glasses _____	YES	NO
Recurrent Eye Infection _____	YES	NO
Stuffy Nose _____	YES	NO
Nose Bleed _____	YES	NO
Recurrent Sore Throats _____	YES	NO
Neck Pain _____	YES	NO
Other _____	YES	NO
3. Heart:		
Chest Pain _____	YES	NO
Rapid, Irregular Beating of Heart _____	YES	NO
Increase in Blood Pressure _____	YES	NO
Swollen Ankles _____	YES	NO
History of Heart Attack _____	YES	NO
Other _____	YES	NO
4. Lungs:		
Difficulty Breathing _____	YES	NO
Chronic Cough _____	YES	NO
Sputum Production _____	YES	NO
Cough Up Blood _____	YES	NO
History of:		
a. Tuberculosis _____	YES	NO
b. Pneumonia _____	YES	NO
Other _____	YES	NO
5. Blood and Lymphatics:		
Bleeding Tendencies _____	YES	NO
Anemia _____	YES	NO
Polycythemia (Too many red blood cells) _____	YES	NO
Swollen Lymph Nodes _____	YES	NO
Easy Bruisability _____	YES	NO
Other _____	YES	NO
6. Gastro-intestinal:		
History of Ulcer _____	YES	NO
History of Gallbladder Disease _____	YES	NO
Hiatal Hernia _____	YES	NO
Vomit Blood _____	YES	NO

Stomach Pain _____	YES	NO
Food Intolerance _____	YES	NO
Yellow Jaundice _____	YES	NO
Rectal Bleeding _____	YES	NO
Hemorrhoids _____	YES	NO
Yellow, Gray, Black or Tarry Bowel Movement _____	YES	NO
Recurrent or Frequent:		
a. Nausea _____	YES	NO
b. Vomiting _____	YES	NO
c. Diarrhea _____	YES	NO
d. Constipation _____	YES	NO
Other _____	YES	NO
7. Genito-urinary:		
Urinary Discomfort _____	YES	NO
Blood in Urine _____	YES	NO
Renal Stone _____	YES	NO
Frequency or Urgency of Urination _____	YES	NO
Get up at night to urinate _____	YES	NO
Venereal Disease _____	YES	NO
Kidney Infection _____	YES	NO
Bladder Infection _____	YES	NO
Other _____	YES	NO
8. Gynecological (If applicable)		
Date of Last Menstrual Period _____		
Vaginal Infection _____	YES	NO
Menstrual Irregularity _____	YES	NO
Severe Menstrual Pain _____	YES	NO
Number of Births:     Live _____		
Still _____		
Abortions _____		
Last Pelvic Exam _____		
Year Stopped Menstruation _____		
9. Neurological:		
Seizures (convulsions) _____	YES	NO
Stroke _____	YES	NO
Difficulty with Coordination _____	YES	NO
Period of Loss of Consciousness _____	YES	NO

Numbness \_\_\_\_\_ YES NO  
Tingling \_\_\_\_\_ YES NO  
Light Headedness \_\_\_\_\_ YES NO  
Other \_\_\_\_\_ YES NO

10. Psychiatric:

Ever Under Major Pressure \_\_\_\_\_ YES NO  
Subject to Depression \_\_\_\_\_ YES NO  
Subject to Anxiety \_\_\_\_\_ YES NO  
Under Care of Psychiatrist \_\_\_\_\_ YES NO  
Other \_\_\_\_\_ YES NO

11. Miscellaneous:

Diabetes \_\_\_\_\_ YES NO  
Thyroid Disease \_\_\_\_\_ YES NO  
Thrombophlebitis \_\_\_\_\_ YES NO  
Blood Clots to the Lung \_\_\_\_\_ YES NO  
Abnormal Masses \_\_\_\_\_ YES NO  
Breast Lumps \_\_\_\_\_ YES NO  
Other \_\_\_\_\_ YES NO

12. Other Data Pertinent To Past History Not Covered By The Above That You Feel We Should Know:

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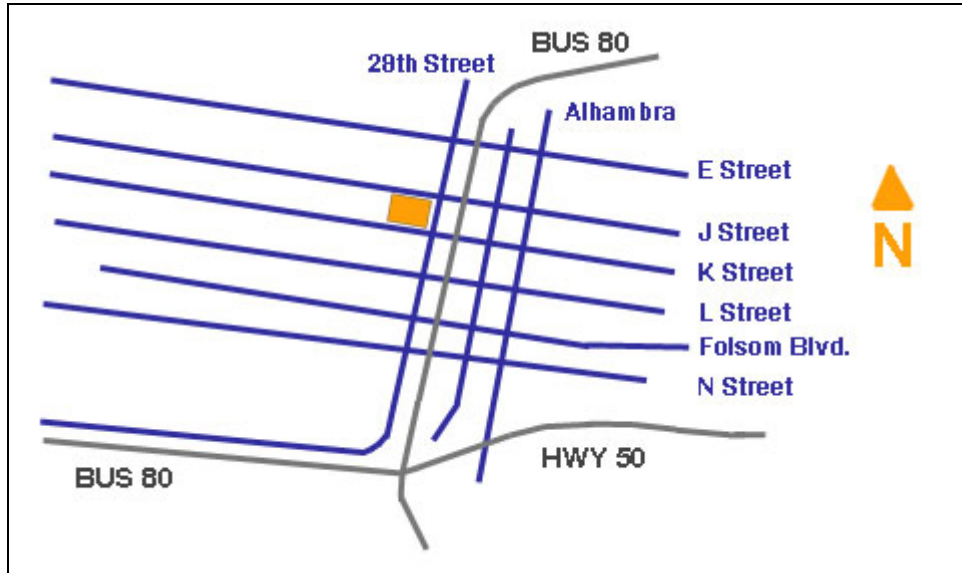
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Directions to NCSRA  
2801 K Street #410  
Sacramento, CA 95816



**From Eastbound Business 80:** Take N Street Exit  
**From Westbound Business 80:** Take J Street Exit

Parking is available in the building. Entrance to parking is on K Street between 28th and 29th streets.