

Low Back Questionnaire

Patient Name: _____

Date: _____

PLEASE READ: this questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that more than one statement may relate to you, but please just circle one choice which most closely describes your problem right now.

SECTION 1 – Pain Intensity

0. I have no pain at the 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.)

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
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 personal care.
5. I do not get dressed, I wash with difficulty, and stay in bed.

SECTION 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives me extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4 – Walking

0. Pain does not prevent me walking any distance.
1. Pain prevents me walking more than 1 mile.
2. Pain prevents me walking more than ¼ of a 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

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

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 more than ½ hour.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

SECTION 7 – Sleeping

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 of sleep.
3. Because of pain, I have less than 4 hours of sleep.
4. Because of pain, I have less than 2 hours of sleep.
5. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

0. My social life is normal and causes me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
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 9 – Traveling

0. I can travel anywhere without pain.
1. I can travel anywhere but it gives me extra pain.
2. The pain is bad, but I manage trips of over 2 hours.
3. Pain restricts me to short trips of less than 1 hour.
4. Pain restricts me to short necessary trips less than 30 minutes.
5. Pain prevents me from traveling except to receive treatment.

SECTION 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but it is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor getting worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient Signature: _____