Oswestry Back Pain Scale

Sum of Scores_______ x 2 = _________ Final Score

Name_________________________________ Date_________________ Visit____________________

Please rate the severity of your pain over the last week by circling a number below.

No pain	0	1	2	3	4	5	6	7	8	9	10	***Unbearable pain***

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 6 – Standing
1. I can stand as long as I want without pain.
2. I have some pain on standing but it does not increase with time.
3. I cannot stand for longer than 1 hour without increasing pain.
4. I cannot stand for longer than 1/2 hour without increasing pain.
5. I cannot stand for longer than 10 minutes without increasing pain.
6. I avoid standing because it increases the pain immediately.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 7 – Sleeping
0. I have no pain in bed.
1. I havepain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than 1/4.
3. Because of pain my normal nights sleep is reduced by less than 1/2.
4. Because of pain my normal nights sleep is reduced by less than 3/4.
5. Pain prevents me from sleeping at all.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

WPT New Patient Information

Patient Name:____________________________Phone #:__________________________

Address:______________________________City/State/Zip:_________________________

DOB:____________Age:__________Social Security #:___________________________

Email Address____

Employer:_________________________________Phone:______________________

Spouse's Name:___________________Number:______________________

Emergency Contact:_________________________Phone:________________________

Referring Physican:_____________________Primary Care Physician:_______________

Is there anyone we can discuss your medical information with? YES NO
Name:_________________________________

How may we contact you regarding appointments? TEXT EMAIL

Have you been a patient before? YES NO
Year:_________Reason:____________

How did you hear about us?
Internet Paper Friend/Family....Name______________

I hereby authorize WPT, through its appropriate personnel to furnish medical care and treatment to me or the above named patient, considered necessary and proper in diagnosing or treating my physical condition.
*Signature:*__________________________________*Date:*_____________________

Acknowledgement of receipt of Notice of Privacy practices.
*Name:*_____________________________________*Date:*______________________

MEDICAL HISTORY---Please circle YES or NO

ALLERGIES	YES	NO
ANEMIA	YES	NO
ANXIETY	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
AUTOIMMUNE DISORDER	YES	NO
CANCER	YES	NO
CARDIAC CONDITIONS	YES	NO
CARDIAC PACEMAKER	YES	NO
CHEMICAL DEPENDENCY	YES	NO
CIRCULATION PROBLEMS	YES	NO
CURRENTLY PREGNANT	YES	NO
DEPRESSION	YES	NO
DIABETES	YES	NO
DIZZY SPELLS	YES	NO
EMPHYSEMA	YES	NO
FIBROMYALGIA	YES	NO
FRACTURES	YES	NO
GALLBLADDER PROBLEMS	YES	NO
HEADACHES	YES	NO
HEARING IMPAIRMENT	YES	NO
HEPATITIS	YES	NO
HIGH CHOLESTEROL	YES	NO
BLOOD PRESSURE	YES	NO
HIV/AIDS	YES	NO
INCONTINENCE	YES	NO
KIDNEY PROBLEMS	YES	NO
METAL IMPLANTS	YES	NO
MRSA	YES	NO
MULTIPLE SCLEROSIS	YES	NO
MUSCULAR DISEASE	YES	NO
OSTEOPEROSIS	YES	NO
PARKINSONS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
SEIZURES	YES	NO
SMOKING	YES	NO
SPEECH	YES	NO
STROKES	YES	NO
THYROID	YES	NO
TUBERCULOSIS	YES	NO
VISION	YES	NO

PLEASE COMPLETE IN FULL

Body Part: ______________________________

☐ Left ☐ Right ☐ Both

Chief Complaint: (Please check all that apply)

☐ Pain ☐ Stiffness ☐ Weakness
☐ Loss of Balance ☐ Loss of function
☐ Other: ______________________________

Have you had an injury as a result of a fall in the past year? Yes NO

Two or more falls in the last year?
YES NO

Have your symptoms been present?

☐ Less than 2 months ☐ 2-3 Months
☐ More than 3 months

Body Height:__________ **Body Weight:**__________

Current Medications:______________________________
____
____

Allergies:______________________________

History of Present Injury:

Severity: (0=no pain 10=worst pain) ______

When:

☐ Sudden ☐ Comes and Goes ☐ Constant
☐ With Movement Only ☐ During Sleep
☐ Other: ______________________________

What else do you experience:

☐ Swelling ☐ Problems Sleeping

Have you previously seen someone for this current problem?

MD Chiropractor PT/OT

Have you had any of the following:

X-ray Bone Scan MRI CT Scan

Where: ______________________________
When: ______________________________