

# LOW BACK PAIN DISABILITY QUESTIONNAIRE

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

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HOW LONG HAVE YOU HAD LOW BACK PAIN?

\_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ DAYS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN \_\_\_\_\_

USE THE LETTERS BELOW TO INDICARE THE TYPE  
AND LOCATION OF YOUR PAIN RIGHT NOW

KEY

A=ACHE

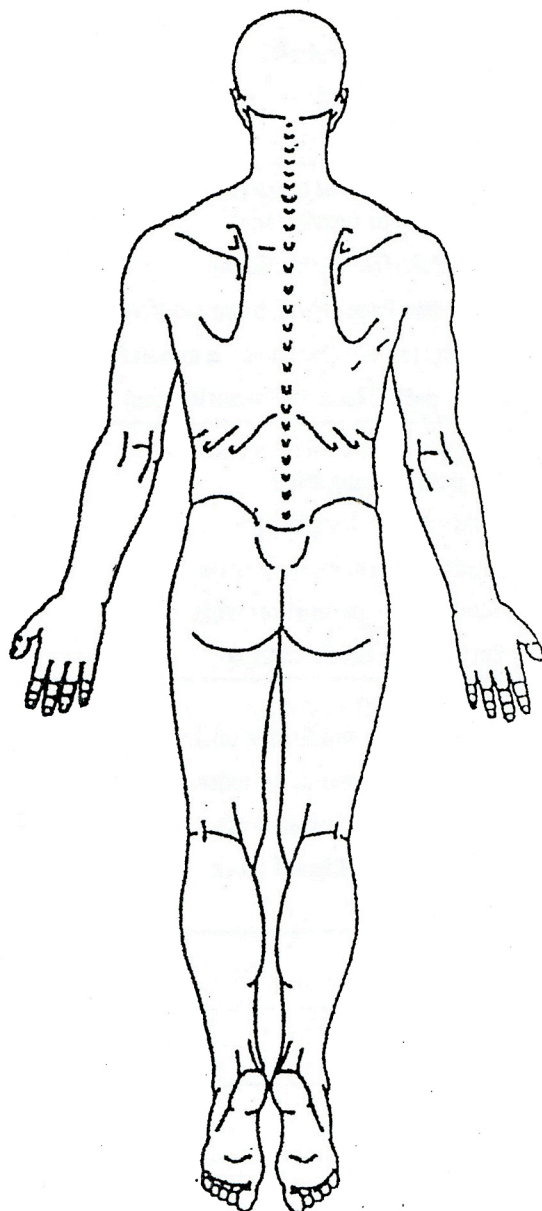
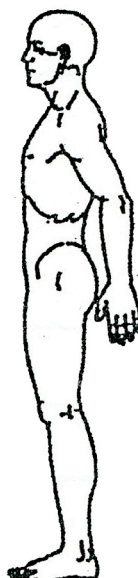
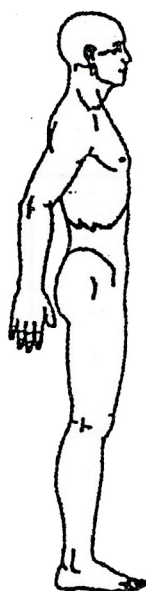
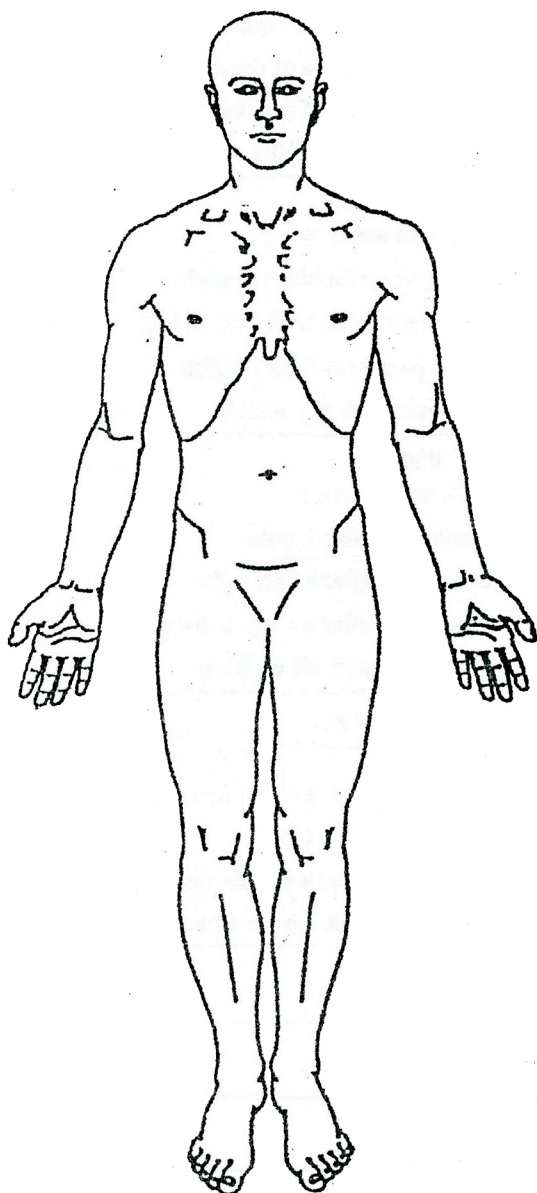
P=PINS AND NEEDLES

B=BURNING

S=STABBING

N=NUMBNESS

O=OTHER



OVER PLEASE

# Functional Rating Index

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

INDEX INSTRUCTIONS: Please choose the answer that best describes each topic.

<p>SECTION 1 - <i>Pain Intensity</i></p> <p>A. <input type="checkbox"/> No Pain</p> <p>B. <input type="checkbox"/> Mild Pain</p> <p>C. <input type="checkbox"/> Moderate Pain</p> <p>D. <input type="checkbox"/> Severe Pain</p> <p>E. <input type="checkbox"/> Worst Possible Pain</p>	<p>SECTION 6 - <i>Recreation</i></p> <p>A. <input type="checkbox"/> Can do all activities</p> <p>B. <input type="checkbox"/> Can do most activities</p> <p>C. <input type="checkbox"/> Can do some activities</p> <p>D. <input type="checkbox"/> Can do few activities</p> <p>E. <input type="checkbox"/> Cannot do any activities</p>
<p>SECTION 2 - <i>Sleeping</i></p> <p>A. <input type="checkbox"/> Perfect sleep</p> <p>B. <input type="checkbox"/> Mildly disturbed</p> <p>C. <input type="checkbox"/> Moderately disturbed</p> <p>D. <input type="checkbox"/> Greatly disturbed</p> <p>E. <input type="checkbox"/> Totally disturbed</p>	<p>SECTION 7 - <i>Frequency of Pain</i></p> <p>A. <input type="checkbox"/> No pain</p> <p>B. <input type="checkbox"/> Occasional pain 25% of the day</p> <p>C. <input type="checkbox"/> Intermittent pain 50% of the day</p> <p>D. <input type="checkbox"/> Frequent pain 75% of the day</p> <p>E. <input type="checkbox"/> Constant pain 100% of the day</p>
<p>SECTION 3 - <i>Personal Care (washing, dressing, etc.)</i></p> <p>A. <input type="checkbox"/> No Pain (No restrictions)</p> <p>B. <input type="checkbox"/> Mild Pain (No restrictions)</p> <p>C. <input type="checkbox"/> Moderate Pain (Need to go slowly)</p> <p>D. <input type="checkbox"/> Moderate Pain (Need some assistance)</p> <p>E. <input type="checkbox"/> Severe pain (Need 100% assistance)</p>	<p>SECTION 8 - <i>Lifting</i></p> <p>A. <input type="checkbox"/> No pain with heavy weight</p> <p>B. <input type="checkbox"/> Increased pain with heavy weight</p> <p>C. <input type="checkbox"/> Increased pain with moderate weight</p> <p>D. <input type="checkbox"/> Increased pain with light weight</p> <p>E. <input type="checkbox"/> Increase pain with any weight</p>
<p>SECTION 4 - <i>Travel (driving, etc.)</i></p> <p>A. <input type="checkbox"/> No pain on long trips</p> <p>B. <input type="checkbox"/> Mild pain on long trips</p> <p>C. <input type="checkbox"/> Moderate pain on long trips</p> <p>D. <input type="checkbox"/> Moderate pain on short trips</p> <p>E. <input type="checkbox"/> Severe pain on short trips</p>	<p>SECTION 9 - <i>Walking</i></p> <p>A. <input type="checkbox"/> No pain; any distance</p> <p>B. <input type="checkbox"/> Increased pain after 1 mile</p> <p>C. <input type="checkbox"/> Increased pain after a half mile</p> <p>D. <input type="checkbox"/> Increased pain after a certain distance</p> <p>E. <input type="checkbox"/> Increased pain with all walking</p>
<p>SECTION 5 - <i>Work</i></p> <p>A. <input type="checkbox"/> Can do usual work plus unlimited extra work</p> <p>B. <input type="checkbox"/> Can do usual work; no extra</p> <p>C. <input type="checkbox"/> Can do 50% of usual work</p> <p>D. <input type="checkbox"/> Can do 25% of usual work</p> <p>E. <input type="checkbox"/> Cannot work</p>	<p>SECTION 10 - <i>Standing</i></p> <p>A. <input type="checkbox"/> No pain after several hours</p> <p>B. <input type="checkbox"/> Increased pain after several hours</p> <p>C. <input type="checkbox"/> Increased pain after 1 hour</p> <p>D. <input type="checkbox"/> Increased pain after a certain duration</p> <p>E. <input type="checkbox"/> Increased pain with any standing</p>

COMMENTS: \_\_\_\_\_

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