Backway's Physical Therapy: **PT Reevaluation Questionnaire** (to be completed every 4-6 weeks)

What changes have you noticed over the past 4-6 weeks? _____

_____

_____

What can you do now that you couldn't do before starting Physical Therapy? _____

_____

What are you currently doing for yourself? _____

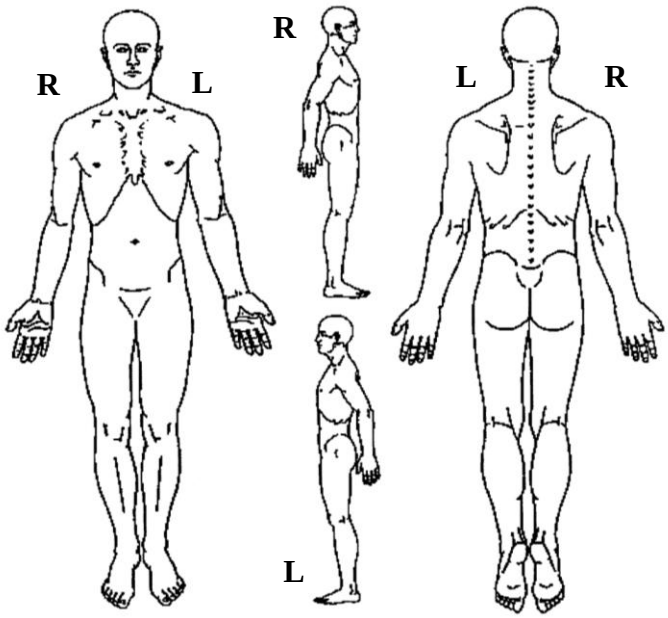
What, about you, is your biggest concern right now? _____

_____

Please indicate on the scale below, by circling numbers, the overall intensity of your symptoms <u>recently</u>:

0	1	2	3	4	5	6	7	8	9
None	vague	minor	mildly uncomfortable	annoying	very uncomfortable	distressing	very intense	excruciating, severe	intolerable

Please indicate on the figures below, the area(s) in which you are experiencing symptoms:



Also, please <u>list</u> your most painful areas below in (1), (2), (3) and then rate each area's pain levels using the 0-9 scale above:

(1) _____
Lowest pain level in past week: ___
Highest pain level in past week: ___
Usual pain level during a normal day: ___
% of time at highest pain level: ___
% Improvement since started PT: ____

(2) _____
Lowest pain level in past week: ___
Highest pain level in past week: ___
Usual pain level during a normal day: ___
% of time at highest pain level: ___
% Improvement since started PT: ____

(3) _____
Lowest pain level in past week: ___
Highest pain level in past week: ___
Usual pain level during a normal day: ___
% of time at highest pain level: ___
% Improvement since started PT: ____

What % of time are you free from pain? _____ (*for PT's use:* Measured Height_____)

Are you doing your Home Exercise Program and Self-care activities on a regular basis? ❑Yes ❑No

If yes, is this controlling your symptoms? _____

If no, why not? _____

Do you feel you need to continue Physical Therapy? ❑Yes ❑No **If yes, what gains do you hope to make if you continue?** _____

_____

Patient name: _____ Date: _____ *(Reevaluation Form Page 1 of 2)*

Backway's PT: Reevaluation Questionnaire: Modified Oswestry Disability Questionnaire

This questionnaire helps us to understand how much your pain affects your ability to perform everyday activities. Please check **the one box in each section** that **most** clearly describes your problem ***RIGHT NOW.***

SECTION 1: Overall Pain Intensity

- ❑ The pain is very mild and comes and goes.
- ❑ The pain is mild and does not vary much.
- ❑ The pain is moderate and comes and goes.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is severe and comes and goes.
- ❑ The pain is severe and does not vary much.

SECTION 2: Personal Care (washing, dressing, etc.)

- ❑ I do not have to change the way I wash and dress myself in order to avoid pain.
- ❑ I do not normally change the way I wash or dress myself even though it causes some pain.
- ❑ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- ❑ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- ❑ Because of the pain, I am partially unable to wash and dress without help.
- ❑ Because of the pain, I am completely unable to wash or dress without help.

SECTION 3: Lifting

- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if they're conveniently positioned (example: on a table, etc.).
- ❑ Pain prevents me from lifting heavy items. I can manage light-medium weights if they're conveniently positioned.
- ❑ I can only lift very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4: Walking

- ❑ I have no pain when walking.
- ❑ I have some pain when walking but I can still walk my required normal distances.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than ½ mile without increasing pain.
- ❑ I cannot walk more than ¼ mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5: Sitting

- ❑ I can sit in any chair as long as I like without pain.
- ❑ I can sit only 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 for more than 10 minutes.
- ❑ I avoid sitting because it increases pain immediately.

SECTION 6: Standing

- ❑ I can stand as long as I want without pain.
- ❑ I can stand as long as I want but some pain develops.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing more than ½ hour.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ I avoid standing because it increases my pain immediately.

SECTION 7: Sleeping

- ❑ I have no pain while in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain, I sleep only ¾ of my normal time.
- ❑ Because of pain, I sleep only ½ of my normal time.
- ❑ Because of pain, I sleep only ¼ of my normal time
- ❑ Pain prevents me from sleeping at all.

SECTION 8: Social Life / Recreation

- ❑ My social/recreation activities are normal and without pain.
- ❑ My social/recreation activities are normal, but increase the degree of pain.
- ❑ Pain has little effect on my social/recreation activities except limiting more energetic interests, e.g. dancing, etc.
- ❑ Pain restricts my social/recreation activities and I do not go out very often.
- ❑ Pain restricts my social/recreation activities to my home.
- ❑ I have hardly any social/recreation life because of pain.

SECTION 9: Traveling / Driving

- ❑ I can travel/drive without increased pain.
- ❑ I can travel/drive unrestricted, but it increases my pain.
- ❑ My pain restricts travel/drives of over 2 hours.
- ❑ My pain restricts my travel/drives of over 1 hour.
- ❑ My pain restricts my travel/driving to short necessary journeys under ½ hour.
- ❑ Pain prevents all forms of travel except that done lying down, or for visits to the doctor, therapist or hospital.

SECTION 10: Employment / Homemaking

- ❑ My normal job/homemaking duties do not cause pain.
- ❑ My normal job/homemaking duties increase my pain, but I can still perform all that is required of me.
- ❑ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities like lifting, vacuuming, etc.
- ❑ Pain prevents me from doing anything but light duties.
- ❑ Pain prevents me from doing even light duties.
- ❑ Pain prevents me from performing any job or homemaking chores.

(for therapist's use only) **DI Score_____%**

Patient name: _____ Date: _____ *(Reevaluation Form Page 2 of 2)*