

### REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

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

HOW LONG HAVE YOU HAD LOW BACK PAIN? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? \_\_\_\_\_ YES \_\_\_\_\_ NO

#### USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:            A=ACHE                      B=BURNING                      N=NUMBNESS  
                  P=PINS & NEEDLES        S=STABBING                    O=OTHER

