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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