

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

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

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Walking

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can only sit 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) Pain prevents me from sitting at all.

6. Standing

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

7. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

8. Social Life

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

9. Traveling

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

ODI © Jeremy Fairbank 1980, All rights reserved. ODI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: contact@mapi-trust.org – Internet: www.mapi-trust.org

Therapist Use Only		
Comorbidities:	Cancer Diabetes Heart Condition High Blood Pressure Multiple Treatment Areas	Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) Obesity Surgery for this Problem Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____

Initial Intake Questionnaire

Body part being seen for: _____

Weight: _____

Height: _____

Date of injury: ____/____/____

Date of Surgery: ____/____/____

Did your symptoms come on as a:

- Gradual process
- New Injury
- Chronic problem

Occupation:

Is the work load:

- Sedentary
- Light
- Medium
- Heavy

Primary concern/complaint:

What is your goal to achieve from physical therapy?

Pain rating: 0=No pain and 10=Severe, unrelenting pain that makes you unable to function at all

Worst (when you have the most pain): 0 1 2 3 4 5 6 7 8 9 10

Current (what it is now): 0 1 2 3 4 5 6 7 8 9 10

Best (when you have the least pain): 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (Circle all that apply): Dull/Achy Sharp Throbbing Burning Shooting

Constant Intermittent

Medications (Please list or provide a list):

I have provided my medication list to the best of my knowledge and will notify my therapist of any changes as they occur.

Signature: _____ Date: ____/____/____

Past Medical History: Check all that apply

<ul style="list-style-type: none"><input type="radio"/> Alzheimer's<input type="radio"/> Cardiovascular Disease<input type="radio"/> Stroke<input type="radio"/> Current Infection<input type="radio"/> Diabetes Mellitus Type 1<input type="radio"/> Diabetes Mellitus Type 2<input type="radio"/> Fibromyalgia<input type="radio"/> Fracture Or Suspected Fracture<input type="radio"/> High Blood Pressure<input type="radio"/> Pacemaker<input type="radio"/> Other (Please describe below)	<ul style="list-style-type: none"><input type="radio"/> History Of Cancer (Describe below) __In Remission __Active<input type="radio"/> Huntington's<input type="radio"/> Immunosuppression<input type="radio"/> Lupus<input type="radio"/> Muscular Dystrophy<input type="radio"/> Obesity<input type="radio"/> Osteoarthritis<input type="radio"/> Parkinson's<input type="radio"/> Rheumatoid Arthritis<input type="radio"/> Traumatic Brain Injury<input type="radio"/> Infectious Disease (Describe below)
---	---

Other:

Only for patients being seen for **Low Back Pain**:

Have you experienced any of the following symptoms?

- Saddle Numbness (numbness in the groin region)

- Problems with urination: (circle all that apply) Incontinence Urgency Can't go

- Problems with bowel: (circle all that apply) Can't control Can't go

Email:

(This is optional, however by providing your email it will allow us to communicate issues regarding your account, updates about our company and allow you an opportunity for online bill pay. We will not share your email with any outside agency except our contracted billing agency, LB Medical Billing, LLC)

How did you hear about us? _____