PD-IW-3

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

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