Rate your back pain on a scale from 1 – 10 with 1 being the least and 10 being the most severe.

1 2 3 4 5 6 7 8 9 10

Office Use		Section 1 – Pain Intensity
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ My pain is mild to moderate. I do not need pain meds.
	2	☐ The pain is bad, but I manage without taking pain meds.
	3	☐ Pain meds give complete relief from pain.
	4	☐ Pain meds give moderate relief from pain.
	5	☐ Pain meds give very little relief from pain
	6	☐ Pain meds have no effect on the pain.

Office Use		Section 2 – Personal Care
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can look after myself normally without causing extra pain.
	2	☐ I can look after myself normally, but it causes extra pain.
	3	☐ It is painful to look after myself, and I am slow and careful.
	4	☐ I need some help but manage most of my personal care.
	5	☐ I need help everyday in most aspects of self-care.
	6	☐ I do not get dressed. I wash with difficulty and stay in bed.

Office Use		Section 3 - Lifting
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can lift heavy weights without causing extra pain.
	2	☐ I can lift heavy weights, but it gives me extra pain.
	3	☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. On a table.
	4	☐ Pain prevents me from lifting heavy weights, but I can manage light weights if items are conveniently positioned.
	5	☐ I can lift only very light weights.
	6	☐ I cannot lift or carry anything at all.

Office Use		Section 4 - Walking
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can walk as far as I wish.
	2	☐ Pain prevents me from walking more than 1 mile.
	3	☐ Pain prevents me from walking more than 1/2 mile.
	4	☐ Pain prevents me from walking more than 1/4 mile.
	5	☐ I can walk only if I use a cane or crutches.
	6	☐ I am in bed or in a chair for most of every day.

Office Use		Section 5 - Sitting
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can sit in any chair for as long as I like.
	2	☐ I can sit in my favorite chair only, but for as long as I like.
	3	☐ Pain prevents me from sitting for more than 1 hour.
	4	☐ Pain prevents me from sitting for more than 1/2 hour.
	5	☐ Pain prevents me from sitting for more than 10 minutes.
	6	☐ Pain prevents me from sitting at all.

Office Use		Section 6 - Standing
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can stand as long as I want without extra pain.
	2	☐ I can stand as long as I want, but it gives me extra pain.
	3	☐ Pain prevents me from standing for more than 1 hour.
	4	☐ Pain prevents me from standing for more than 1/2 hour.
	5	☐ Pain prevents me from standing for more than 10 minutes.
	6	☐ Pain prevents me from standing at all.

Office Use		Section 7 - Sleeping
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ Pain does not prevent me from sleeping well.
	2	☐ I sleep well but only when taking medication.
	3	☐ Even when I take medication, I sleep less than 6 hours.
	4	☐ Even when I take medication, I sleep less than 4 hours.
	5	☐ Even when I take medication, I sleep less than 2 hours.
	6	☐ Pain prevents me from sleeping at all.

Office Use		Section 8 – Social Life
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ Social life is normal and causes me no extra pain.
	2	☐ Social life is normal, but increases the degree of pain.
	3	☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
	4	☐ Pain has restricted my social life, and I do not go out as often.
	5	☐ Pain has restricted my social life to my home.
	6	☐ I have no social life because of pain.

Office Use		Section 9 – Changing Degree of Pain
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ My pain is rapidly getting better.
	2	☐ My pain fluctuates, but overall is definitely getting better.
	3	☐ My pain seems to be getting better, but improvement is slow at present.
	4	☐ My pain is neither getting better nor worse.
	5	☐ My pain is gradually worsening.

Office Use		Section 10 - Traveling
Please check **1** box per section that best describes how you're feeling today.	**1**	☐ I can travel anywhere without extra pain.
	2	☐ I can travel anywhere, but it gives me extra pain.
	3	☐ Pain is bad, but I manage journeys over 2 hours.
	4	☐ Pain restricts me to journeys of less than 1 hour.
	5	☐ Pain restricts me to necessary journeys under 1/2/ hour.
	6	☐ Pain prevents me from traveling except to the Doctor/Hospital.

PATIENT SIGNATURE _____ **DATE** _____ **DISABILITY SCORE** _____

PRINT NAME _____