

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME: _____

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

