

Name: _____ MR: _____ Date: ____/____/____

ROLAND-MORRIS DISABILITY QUESTIONNAIRE FOR LOW BACK PAIN

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. When you read a sentence that describes you *today*, mark the box next to it. If the sentence does not describe you, then leave the space blank and go on to the next one. **Remember, only mark the sentence if you are sure that it describes you today.**

1. ☐ I stay at home most of the time because of the pain in my back.
2. ☐ I change position frequently to try and make my back comfortable.
3. ☐ I walk more slowly than usual because of the pain in my back.
4. ☐ Because of the pain in my back, I am not doing any of the jobs that I usually do around the house.
5. ☐ Because of the pain in my back, I use a handrail to get upstairs.
6. ☐ Because of the pain in my back, I lie down to rest more often.
7. ☐ Because of the pain in my back, I have to hold on to something to get out of a reclining chair.
8. ☐ Because of the pain in my back, I ask other people to do things for me.
9. ☐ I get dressed more slowly than usual because of the pain in my back.
10. ☐ I only stand up for short periods of time because of the pain in my back.
11. ☐ Because of the pain in my back, I try not to bend or kneel down.
12. ☐ I find it difficult to get out of a chair because of the pain in my back.
13. ☐ My back hurts most of the time.
14. ☐ I find it difficult to turn over in bed because of the pain in my back.
15. ☐ My appetite is not very good because of the pain in my back.
16. ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
17. ☐ I only walk short distances because of the pain in my back.
18. ☐ I sleep less because of the pain in my back.
19. ☐ Because of the pain in my back, I get dressed with help from someone else.
20. ☐ I sit down for most of the day because of the pain in my back.
21. ☐ I avoid heavy jobs around the house because of the pain in my back.
22. ☐ Because of the pain in my back, I am more irritable and bad tempered with people.
23. ☐ Because of the pain in my back, I go upstairs more slowly than usual.
24. ☐ I stay in bed most of the time because of the pain in my back.

Total Score: _____

Therapist: _____ Therapist Signature: _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Unbearable pain

Name _____ Date _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only 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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Name: _____ Date: ____/____/____ MR: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your
work, take care of things at home, or get along with other people?

Not difficult
at all

☐

Somewhat
difficult

☐

Very
difficult

☐

Extremely
difficult

☐

Therapist: _____ Therapist Signature: _____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from
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Name: _____ MR: _____ Date: ____/____/____

GAD-7

Over the last 2 weeks, how often have you
been bothered by the following problems?

Not
at all

Several
days

More than
half the
days

Nearly
every day

(Use "✓" to indicate your answer)

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T ____ = ____ + ____ + ____)

Severity Range:

___ 0-4: Minimum

___ 5-9: Mild

___ 10-14: Moderate

___ 15-21: Severe

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COLUMBIA-SUICIDE SEVERITY RATING SCALE
 Screener/Recent - Self-Report

Name: _____ MR: _____ Date: ____/____/____		In The Past Month	
Answer Questions 1 and 2		YES	NO
1) <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>			
2) <i>Have you actually had any thoughts about killing yourself?</i>			
If YES to 2, answer questions 3, 4, 5, and 6. If NO to 2, go directly to question 6			
3) <i>Have you thought about how you might do this?</i>			
4) <i>Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?</i>			
5) <i>Have you started to work out or worked out the details of how to kill yourself?</i> <i>Do you intend to carry out this plan?</i>			
		In the Past 3 Months	
6) <i>Have you done anything, started to do anything, or prepared to do anything to end your life?</i>			
<p>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</p> <p><i>In your entire lifetime, how many times have you done any of these things?</i></p>			

Therapist Name: _____ Therapist Signature: _____

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Alcohol Use Disorders Identification Test – AUDIT

Please select the answer that is most correct for you to each of the following questions.

- 1) How often do you have a drink containing alcohol? *(If you answer never, jump to questions 9&10)*
(0) Never (1) Monthly or less (2) 2-4 times a month (3) 2-3 times per week (4) 4 or more times a week
- 2) How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3-4 (2) 5-6 (3) 7-8 (4) 10 or more
- 3) How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 4) How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 5) How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 7) How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 8) How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- 9) Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (3) Yes, during the last year
- 10) Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (3) Yes, during the last year

Total Score: _____

Therapist: _____ Therapist Signature: _____

MR: _____

Patient's Name: _____

Date: _____

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Total Score: _____

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test.

J Subst Abuse Treatment 2007;32:189-198

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Rosenberg's Self-Esteem Scale (Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I feel that I'm a person of worth, at least on an equal plane with others.				
2. I feel that I have a number of good qualities.				
3. All in all, I am inclined to feel that I am a failure.				
4. I am able to do things as well as most other people.				
5. I feel I do not have much to be proud of.				
6. I take a positive attitude toward myself.				
7. On the whole, I am satisfied with myself.				
8. I wish I could have more respect for myself.				
9. I certainly feel useless at times.				
10. At times I think I am no good at all.				

Total Score: _____

Scoring: To score the items, assign a value to each of the 10 items as follows:

- **For items 1, 2, 4, 6, 7:** Strongly Agree=3, Agree=2, Disagree=1, and Strongly Disagree=0.
- **For items 3, 5, 8, 9, 10** (which are reversed in valence, and noted with the asterisks** below): Strongly Agree=0, Agree=1, Disagree=2, and Strongly Disagree=3.

The scale ranges from 0-30, with 30 indicating the highest score possible. Higher scores indicate higher self-esteem. Scores below 15 indicate low self-esteem.

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Satisfaction With Life Scale (SWLS)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 - Strongly agree

6 - Agree

5 - Slightly agree

4 - Neither agree nor disagree

3 - Slightly disagree

2 - Disagree

1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

Total Score: _____

Severity Range:

31 – 35: Extremely satisfied

26 – 30: Satisfied

21 – 25: Slightly satisfied

20: Neutral

15 – 19: Slightly dissatisfied

10 – 14: Dissatisfied

5 - 9: Extremely dissatisfied

Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality Assessment*.

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