

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
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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: _____ MR: _____ Date: ___/___/___

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
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 _____ = _____ + _____ + _____)

Severity Range:

___ 0-4: Minimum

___ 5-9: Mild

___ 10-14: Moderate

___ 15-21: Severe

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CIDI Based Bipolar Disorder Screening Scale

	YES	NO
<p><i>Euphoria Stem Question:</i></p> <p>1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?</p> <p><i>If the answer is YES, skip to Criterion B screening question (3). If the answer is NO, answer the Irritability Stem Question next.</i></p>		
<p><i>Irritability Stem Question:</i></p> <p>2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?</p> <p><i>If the answer is YES, continue to Criterion B screening question (3). If the answer is NO, don't answer any more questions.</i></p>		
<p><i>Criterion B Screening Question:</i></p> <p>3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?</p> <p><i>If the answer is YES, continue to answer the rest of the questions in this form. If the answer is NO, don't answer any more questions.</i></p>		
<p><i>Criterion B Symptom Questions:</i></p> <p>Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?</p>		
<p>1. Where you so irritable that you either started arguments, shouted at people or hit people?</p> <p><i>This first symptom question should be answered only if the euphoria stem question #1 was answered YES.</i></p>		
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?		
3. Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?		
4. Did you try to do things that were impossible to do, like taking on large amounts of work?		
5. Did you constantly keep changing your plans or activities?		
6. Did you find it hard to keep your mind on what you were doing?		
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?		
8. Did you sleep far less than usual and still not get tired or sleepy?		
9. Did you spend so much more money than usual that it caused you to have financial trouble?		

Total: _____

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

Name: _____ MR: _____ Date: ___/___/___

Answer Questions 1 and 2 // In the past month...	In The Past Month	
	YES	NO
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If YES to 2, answer questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) 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?		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
	In the Past 3 Months	
6) Have you done anything, started to do anything, or prepared to do anything to end your life? 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. In your entire lifetime, how many times have you done any of these things?		

Total: _____

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Name: _____ MR: _____ Date: ___/___/___

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: _____

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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

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Name: _____

Date: ___/___/___

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
 0 1 2 3 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all
 Noticeable A Little Somewhat Much Very Much Noticeable
 0 1 2 3 4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all
 Worried A Little Somewhat Much Very Much Worried
 0 1 2 3 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all
 Interfering A Little Somewhat Much Very Much Interfering
 0 1 2 3 4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score

Total score categories:

0–7 = No clinically significant insomnia

8–14 = Subthreshold insomnia

15–21 = Clinical insomnia (moderate severity)

22–28 = Clinical insomnia (severe)

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

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

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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