

# SI JOINT OSWESTRY INDEX

**Please Read:** This questionnaire is designed to enable us to understand how much your back pain has affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please answer based upon your average pain over the past two weeks **without pain medication.**

**SECTION 1-Pain intensity**

- 0 I have no pain at this moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

**SECTION 2-Personal Care (washing, dressing, etc)**

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally, but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help, but manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I do not get dressed, wash with difficulty, and stay in bed.

**SECTION 3- Lifting**

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift only very light weights.
- 5 I cannot lift or carry anything at all.

**SECTION 4- Walking**

- 0 Pain does not prevent me walking any distance.
- 1 Pain prevents me from walking for more than 1 mile.
- 2 Pain prevents me from walking for more than ¼ mile.
- 3 Pain prevents me from walking more than 100 yards.
- 4 I can only walk using a stick or crutches.
- 5 I am in bed most of the time and have to crawl to the toilet.

**SECTION 5- Sitting**

- 0 I can sit in any chair as long as I like.
- 1 I can sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting for more than 1 hour.
- 3 Pain prevents me from sitting for more than ½ hour.
- 4 Pain prevents me from sitting for more than 10 minutes.
- 5 Pain prevents me from sitting at all.

**SECTION 6 – Standing**

- 0 I can stand as long as I want without extra pain.
- 1 I can stand as long as I want, but it gives me extra pain.
- 2 Pain prevents me from standing more than 1 hour.
- 3 Pain prevents me from standing for more than ½ hour.
- 4 Pain prevents me from standing for more than 10 minutes.
- 5 Pain prevents me from standing at all.

**SECTION 7- Sleeping**

- 0 My sleep is never disturbed by pain.
- 1 My sleep is occasionally disturbed by pain.
- 2 Because of pain I have less than 6 hours sleep.
- 3 Because of pain I have less than 4 hours sleep.
- 4 Because of pain I have less than 2 hours sleep
- 5 Pain prevents me from sleeping at all.

**SECTION 8 – Sex Life**

- 0 My sex life is normal and causes no extra pain.
- 1 My sex life is normal, but causes some pain.
- 2 My sex life is nearly normal, but is very painful.
- 3 My sex life is severely restricted by pain.
- 4 My sex life is nearly absent because of back pain
- 5 I have no sex life because of pain.

**SECTION 9 – Social Life**

- 0 My social life is normal and gives me no extra pain.
- 1 My social life is normal, but increases the degree of pain.
- 2 Pain has no effect on my social life apart from limiting my more energetic interests
- 3 Pain has restricted my social life and I do not go out as often.
- 4 Pain has restricted my social life to my home.
- 5 I have no social life because of pain.

**SECTION 10- Traveling**

- 0 I can travel anywhere without extra pain.
- 1 I can travel anywhere, but it gives extra pain.
- 2 Pain is bad, but I manage journeys over two hours.
- 3 Pain restricts me to journeys of less than one hour.
- 4 Pain restricts me to short necessary journeys less than 30 minutes
- 5 Pain prevents me from traveling except to receive treatment.

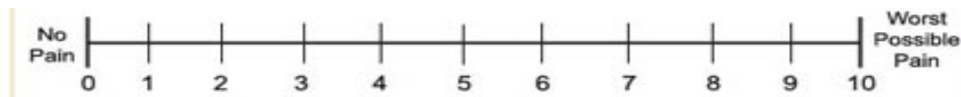
Print Name: \_\_\_\_\_

By entering my name above, I affirm all of this information is correct.

**DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Score:** \_\_\_\_\_ %

**RATE YOUR PAIN ON A SCALE OF 1-10 BY PLACING A NUMBER IN EACH OF THE BLANK SPACES:**



OVERALL PAIN \_\_\_\_\_  
LOW BACK \_\_\_\_\_

LEG (LEFT) \_\_\_\_\_  
LEG (RIGHT) \_\_\_\_\_

BUTTOCK (LEFT) \_\_\_\_\_  
BUTTOCK (RIGHT) \_\_\_\_\_

**IF YOU ARE POST-OP: (Please complete the following)**

1. Overall were you satisfied with your surgery? YES  NO     2. Returned to work after surgery? YES  NO   
3. If given the chance would you repeat the same surgery for the same outcome? YES  NO     4. Retired? YES  NO

Pre-Op     6 Wks     3 Mon     6 Mon     1 Year     2 Year     3 Year     4 Year     5 Year