



BRISTOL PHYSICAL THERAPY, LLC
"One on One"
Manual Therapy and Exercise

Name: _____ Date: _____

During the last week and because of your back problems due to osteoporosis,

1. How often have you had back pain in the last week?

- 1. I have not had back pain
- 2. 1 day
- 3. 2-3 days
- 4. 4-6 days
- 5. Every day

2. How severe is your back pain?

- 1. I have not had back pain
- 2. Mild
- 3. Moderate
- 4. Severe
- 5. Intolerable

3. How much distress or discomfort have you had because it has been painful to stand for a long time?

- 1. No discomfort or suffering
- 2. Slight discomfort or suffering
- 3. Moderate discomfort or suffering
- 4. Severe discomfort or suffering
- 5. Very severe discomfort or suffering

4. How much distress or discomfort have you had due to pain from bending?

- 1. No discomfort or suffering
- 2. Slight discomfort or suffering
- 3. Moderate discomfort or suffering
- 4. Severe discomfort or suffering
- 5. Very severe discomfort or suffering

Badia X1, Díez-Pérez A, et al. (2004). "The ECOS-16 questionnaire for the evaluation of health related quality of life in post-menopausal women with osteoporosis." Health Qual Life Outcomes 2:41



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5. Has the back pain disturbed your sleep in the last week?

- 1. On no occasion
- 2. One night
- 3. Two nights
- 4. Three or four nights
- 5. Every night

6. How difficult has it been for you to carry out the household activities?

- 1. No difficulty
- 2. Slight difficulty
- 3. Moderate difficulty
- 4. Great difficulty
- 5. I was unable to do anything

7. Can you climb stairs to the next floor of a house?

- 1. No difficulty
- 2. Slight difficulty
- 3. I had to rest at least once
- 4. I could only climb the stairs with help
- 5. I was unable to climb the stairs

8. Do you have problems with dressing?

- 1. No difficulty
- 2. I can dress myself with slight difficulty
- 3. I can dress myself with moderate difficulty
- 4. I sometimes need help to dress myself
- 5. I cannot dress myself unaided

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9. How difficult has it been for you to bend?

- 1. No difficulty
- 2. Slight difficulty
- 3. Moderate difficulty
- 4. Great difficulty
- 5. I am unable to bend down

10. How much has your walking been limited?

- 1. Not limited
- 2. Slightly limited
- 3. Moderately limited
- 4. Very limited
- 5. I am unable to walk

11. How difficult has it been for you to visit friends or relatives?

- 1. No difficulty
- 2. Slight difficulty
- 3. Moderate difficulty
- 4. Great difficulty
- 5. I have been unable to visit family or friends

12. Do you feel downhearted?

- 1. No
- 2. Rarely
- 3. Sometimes
- 4. Often
- 5. Always

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13. Are you hopeful about your future?

- 1. Always
- 2. Often
- 3. Sometimes
- 4. Rarely
- 5. No

14. Do you feel frustrated?

- 1. No
- 2. Rarely
- 3. Sometimes
- 4. Often
- 5. Always

15. Are you afraid of falling?

- 1. No
- 2. Rarely
- 3. Sometimes
- 4. Often
- 5. Always

16. Are you afraid of getting a fracture?

- 1. No
- 2. Rarely
- 3. Sometimes
- 4. Often
- 5. Always

Score: Total ____/16 = ____ subtract 1, (multiply by .25 for % disability= ____%)

MCID (Minimal Clinically Important Difference) = 0.5 points (10%)

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