Örebro Musculoskeletal Pain Screening Questionnaire (Short)

Name: _______________________________ Date of Birth: ____________

Are you:  □ Male  □ Female

1. How long have you had your current pain problem? Tick (√) one.


2. How would you rate the pain that you have had during the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10

No pain  Pain as bad as it could be

Please circle the one number which best describes your current ability to participate in each of these activities.

3. I can do light work for an hour.

0 1 2 3 4 5 6 7 8 9 10

Can’t do it because Can do it without pain
of the pain problem being a problem

4. I can sleep at night.

0 1 2 3 4 5 6 7 8 9 10

Can’t do it because Can do it without pain
of the pain problem being a problem

5. How tense or anxious have you felt in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10

Absolutely calm and relaxed As tense and anxious as I’ve ever felt

6. How much have you been bothered by feeling depressed in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10

Not at all Extremely

7. In your view, how large is the risk that your current pain may become persistent?

0 1 2 3 4 5 6 7 8 9 10

No risk Very large risk

8. In your estimation, what are the chances you will be working your normal duties in 3 months

0 1 2 3 4 5 6 7 8 9 10

No chance Very Large Chance

Here are some of the things which other people have told us about their pain. For each statement please circle one number from 0-10 to say how much physical activities, such as bending, lifting, walking, or driving affect your pain.

9. An increase in pain is an indication that I should stop what I’m doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree Completely agree

10. I should not do my normal work with my present pain.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree Completely agree

SUM: