

Samuel K. Cho, M.D.
Spinal Deformity Questionnaire

Name: _____

DOB: _____

Today's Date: _____

Exam: Pre-treatment 6 wks. 3 mos. 6 mos. 1 year _____ years

Please read the instructions:

This questionnaire has been designed to give the doctor information as to how your overall health and back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Scoliosis Research Society Questionnaire

SECTION 1 – ALL PATIENTS

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
 None Mild Moderate Moderate to severe Severe
2. Which one of the following best describes the amount of pain you have experienced over the last month?
 None Mild Moderate Moderate to severe Severe
3. During the past 6 months have you been a very nervous person?
 None of the time A little of the time Some of the time Most of the time All of the time
4. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?
 Very happy Somewhat happy Neither happy nor unhappy Somewhat unhappy Very unhappy
5. What is your current level of activity?
 Bedridden/wheelchair
 Primarily no activity
 Light labor, such as household chores
 Moderate manual labor and moderate sports, such as walking and biking
 Full activities without restriction
6. How do you look in clothes?
 Very good Good Fair Bad Very bad
7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
 Very often Often Sometimes Rarely Never
8. Do you experience back pain when at rest?
 Very often Often Sometimes Rarely Never
9. What is your current level of work/school activity?
 100% normal 75% normal 50% normal 25% normal 0% normal
10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
 Very good Good Fair Poor Very poor
11. Which one of the following best describes your medication usage for your back?
 None
 Non-narcotics weekly or less (e.g., Tylenol, ibuprofen)
 Non-narcotics daily
 Narcotics weekly or less (e.g., Percocet, Vicodine, Codeine)
 Narcotics daily
 Other (please specify below)
 Medication: _____
 Usage (weekly or less or daily): _____
12. Does your back limit your ability to do things around the house?
 Never Rarely Sometimes Often Very often

13. Have you felt calm and peaceful during the past 6 months?
 All of the time Most of the time Some of the time A little of the time None of the time
14. Do you feel that your back condition affects your personal relationships?
 None Slightly Mildly Slightly None
15. Are you and/or your family experiencing financial difficulties because of your back?
 Severely Moderately Mildly Slightly None
16. In the past 6 months have you felt downhearted and blue?
 Never Rarely Sometimes Often Very often
17. In the last 3 months have you taken any sick days from work/school due to back pain and, if so, how many?
 0 1 2 3 4 or more
18. Do you go out more or less than your friends?
 Much more More Same Less Much less
19. Do you feel attractive with your current back condition?
 Yes, very Yes, somewhat Neither attractive nor unattractive No, not very much No, not at all
20. Have you been a happy person during the past 6 months?
 None of the time A little of the time Some of the time Most of the time All of the time
21. Are you satisfied with the results of your back management?
 Very satisfied Satisfied Neither satisfied nor unsatisfied Unsatisfied Very unsatisfied
22. Would you have the same management again if you had the same condition?
 Definitely yes Probably yes Not sure Probably not Definitely not
23. On a scale of 1 to 9, with 1 being very low and 9 being extremely high, how would you rate your self-image?
 1 2 3 4 5 6 7 8 9

SECTION 2 – POST-SURGERY PATIENTS ONLY

24. Compared with before treatment, how do you feel you now look?
 Much better Better Same Worse Much worse
25. Has your back treatment changed your function and daily activity?
 Increased Not changed Decreased
26. Has your back treatment changed your ability to enjoy sports/hobbies?
 Increased Not changed Decreased
27. Has your back treatment _____ your back pain?
 Increased Not changed Decreased
28. Has your treatment changed your confidence in personal relationships with others?
 Increased Not changed Decreased
29. Has your treatment changed the way others view you?
 Much better Better Same Worse Much worse
30. Has your treatment changed your self-image?
 Increased Not changed Decreased

Modified Oswestry Disability Index**SECTION 1 – PAIN INTENSITY**

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain, I do not use them.

SECTION 2 – PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ½ mile.
- Pain prevents me walking more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than thirty minutes.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

SECTION 6 – STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than one hour.
- Pain prevents me from standing more than thirty minutes.
- Pain prevents me from standing more than ten minutes.
- Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than six hours sleep.
- Even when I take tablets I have less than four hours sleep.
- Even when I take tablets I have less than two hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8 – EMPLOYMENT/HOMEMAKING

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities like lifting, vacuuming, etc.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

SECTION 9 – SOCIAL LIFE

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

SECTION 10 – TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys less than one hour.
- Pain restricts me to short journeys under thirty minutes.
- Pain prevents me from traveling except to the doctor or hospital.

General Health Status Questionnaire

- In general, would you say your health is... (Mark only one)
 Excellent Very Good Good Fair Poor
- Compared to one year ago**, how would you rate your health in general **now**? (Mark only one)
 Much better Somewhat better About the same Somewhat worse Much worse

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
 (Fill in only one circle on each line)

- | | Yes,
Limited
a Lot | Yes,
Limited
a Little | No, Not
Limited
At All |
|---|--------------------------|-----------------------------|------------------------------|
| 3. Vigorous activities such as running, lifting heavy objects, or participating in strenuous sports. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Lifting or carrying groceries. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Climbing several flights of stairs. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Climbing one flight of stairs. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Bending, kneeling, or stooping. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Walking more than a mile . | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Walking several blocks . | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Walking one block . | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Bathing or dressing yourself. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Fill in only one circle on each line)

- | | Yes | No |
|---|-----------------------|-----------------------|
| 13. Cut down the amount of time you spent on work or other activities. | <input type="radio"/> | <input type="radio"/> |
| 14. Accomplished less than you would like. | <input type="radio"/> | <input type="radio"/> |
| 15. Were limited in the kind of work or other activities. | <input type="radio"/> | <input type="radio"/> |
| 16. Had difficulty performing the work or other activities (e.g., it took extra effort). | <input type="radio"/> | <input type="radio"/> |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Fill in only one circle on each line)

- | | Yes | No |
|---|-----------------------|-----------------------|
| 17. Cut down the amount of time you spent on work or other activities. | <input type="radio"/> | <input type="radio"/> |
| 18. Accomplished less than you would like. | <input type="radio"/> | <input type="radio"/> |
| 19. Didn't do work or other activities as carefully as usual. | <input type="radio"/> | <input type="radio"/> |

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Mark only one)
 Not at all Slightly Moderately Quite a bit Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**? (Mark only one)
 None Very mild Mild Moderate Severe Very severe

22. During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and house work)? (Mark only one)
 Not at all A little bit Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much time **during the past 4 weeks**... (Fill in only one circle on each line)

- | | All of
the Time | Most of
the Time | A Good Bit
of the Time | Some of
the Time | A Little of
the Time | None of
the Time |
|---|-----------------------|-----------------------|---------------------------|-----------------------|-------------------------|-----------------------|
| 23. Did you feel full of pep (happy)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. Have you been a very nervous person? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. Have you felt so down in the dumps that nothing could cheer you up? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Have you felt calm and peaceful? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Did you have a lot of energy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Have you felt downhearted and blue? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Did you feel worn out? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Have you been a happy person? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. Did you feel tired? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relative, etc.)? (Mark only one)
 Not at all A little bit Moderately Quite a bit Extremely

How **TRUE** or **FALSE** is **each** of the following statements for you? (Fill in only one circle on each line)

- | | Definitely
True | Mostly
True | Don't
Know | Mostly
False | Definitely
False |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 33. I seem to get sick a little easier than other people. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. I am as healthy as anybody I know. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 35. I expect my health to get worse. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 36. My health is excellent. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |