

**Scoliosis Patient Questionnaire:
Version 30 (Encompasses Versions 22 and 24)**

Created: 9/25/03

Patient Name: _____	Age: _____	Date: _____			
Medical Record # _____	SS: _____				
Exam:	Pre-treatment	3 mos.	6 mos.	1 year	_____ years

Your doctors are carefully evaluating the condition of your back before and after your treatment. Please circle the one best answer to each question unless otherwise indicated. If you already have had surgery, please complete sections 1 and 2. Otherwise, just complete section 1.

All results will be kept confidential.

Section 1: All patients

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

12. **Does your back limit your ability to do things around the house?**

- Never Often
 Rarely Very often
 Sometimes

13. **Have you felt calm and peaceful during the past 6 months?**

- All of the time A little of the time
 Most of the time None of the time
 Some of the time

14. **Do you feel that your back condition affects your personal relationships?**

- None Moderately
 Slightly None
 Mildly

15. **Are you and/or your family experiencing financial difficulties because of your back?**

- Severely Slightly
 Moderately None
 Mildly

16. **In the past 6 months have you felt down-hearted and blue?**

- Never Often
 Rarely Very often
 Sometimes

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 Less
 More Much less
 Same

19. **Do you feel attractive with your current back condition?**

- Yes, very No, not very much
 Yes, somewhat No, not at all
 Neither attractive nor unattractive

20. **Have you been a happy person during the past 6 months?**

- None of the time Most of the time
 A little of the time All of the time
 Some of the time

21. **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

22. **Are you satisfied with the results of your back management?**

- Very satisfied Unsatisfied
 Satisfied Very unsatisfied
 Neither satisfied nor unsatisfied

23. **Would you have the same management again if you had the same condition?**

- Definitely yes Probably not
 Probably yes Definitely not
 Not sure

Section 2: Post-surgery patients only

24. **Compared with before treatment, how do you feel you now look?**

- Much better Worse
 Better Much worse
 Same

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 Worse
 Better Much worse
 Same

30. **Has your treatment changed your self-image?**

- Increased Not changed Decreased

Please mark on the drawings any areas where you feel pain. If you are not having any pain, leave blank and initial.

Use the following key to show particular types of pain

KEY:

Pins & needles = 000000

Burning = XXXXXX

Stabbing = /////

Deep ache = ZZZZZZ

