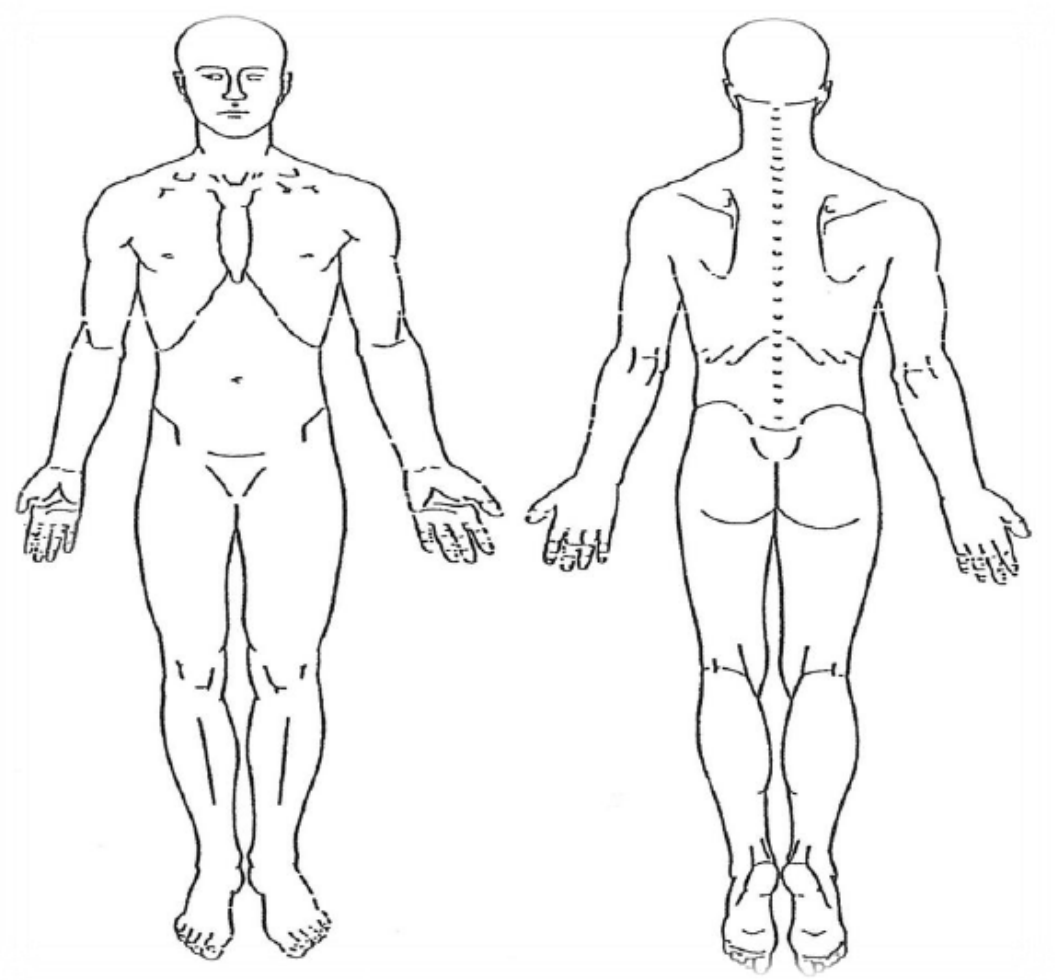
# Mr M J H McCarthy
# Consultant Spinal Surgeon
# Patient Reported Outcome Measures

*Affix Patient Label*

This document contains a series of standard assessments that are very useful in helping us assess your spinal problem. The questions also help to determine whether or not there has been any benefit from the treatments you have received.

**Todays Date:**

**Where is your pain / problem located?**
Please shade the pain / problem areas on the diagram and mark the worst affected area.



**On a scale of 0 to 10, how much neck / back pain have you felt over the last month?**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**On a scale of 0 to 10, how much arm / leg pain have you felt over the last month?**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**PLEASE ANSWER BY CIRCLING THE WORDS THAT BEST FIT YOUR PROBLEM**

**Which of these problems is the worst for you?**

Neck / Low Back pain  Arm / Leg pain  Sensory changes  Other:

**During the past week, how much did your problem interfere with your normal work (including housework)?**

Not at all  Little bit  Moderately  Quite a bit  Extremely

**If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?**

Very satisfied  Somewhat satisfied  Ambivalent  Dissatisfied  Very dissatisfied

**Please reflect on your last week. How would you rate your quality of life?**

Very good  Good  Moderate  Bad  Very bad

**During the past 4 weeks, how many days did you cut down on the things you usually do (work, housework, recreational activities) because of your problem?**

None  1-7 days  8-14 days  15-21 days  >21 days

**During the past 4 weeks, how many days did your problem keep you from going to work (job, school, housework)?**

None  1-7 days  8-14 days  15-21 days  >21 days

**How far can you walk?**

100 yards  200 yards  400 yards  800 yards  1 mile or more

**What is your current work status? E.g. Student, housewife, working, retired, disabled**

……..

**How much time have you lost from work in the last year?**

None  less than a week  one to three weeks
three to six weeks  six to twelve weeks  three to six months
six to twelve months  more than one year

**Is there any personal injury claim pending regarding your spinal problem?**  Yes  No

**Are you receiving disability benefit?**  Yes  No

**Have you had to retire because of your spine?**  Yes  No

**Have you had previous spinal surgery?**  Yes  No

**Do you smoke?**  Yes  No

## EQ5D

Under each heading, please tick the ONE box that best describes your health **TODAY**:

**MOBILITY**
- I have no problems in walking about ❑
- I have slight problems in walking about ❑
- I have moderate problems in walking about ❑
- I have severe problems in walking about ❑
- I am unable to walk about ❑

**SELF-CARE**
- I have no problems washing or dressing myself ❑
- I have slight problems washing or dressing myself ❑
- I have moderate problems washing or dressing myself ❑
- I have severe problems washing or dressing myself ❑
- I am unable to wash or dress myself ❑

**USUAL ACTIVITIES** *(e.g. work, study, housework, family or leisure activities)*
- I have no problems doing my usual activities ❑
- I have slight problems doing my usual activities ❑
- I have moderate problems doing my usual activities ❑
- I have severe problems doing my usual activities ❑
- I am unable to do my usual activities ❑

**PAIN / DISCOMFORT**
- I have no pain or discomfort ❑
- I have slight pain or discomfort ❑
- I have moderate pain or discomfort ❑
- I have severe pain or discomfort ❑
- I have extreme pain or discomfort ❑

**ANXIETY / DEPRESSION**
- I am not anxious or depressed ❑
- I am slightly anxious or depressed ❑
- I am moderately anxious or depressed ❑
- I am severely anxious or depressed ❑
- I am extremely anxious or depressed ❑

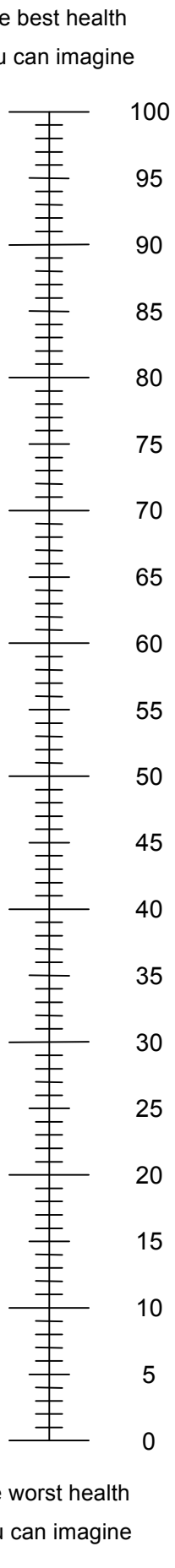
We would like to know how good or bad your health is **TODAY**.

The scale on the right is numbered from 0 to 100.

100 means the best health you can imagine.

0 means the worst health you can imagine.

Please mark an X on the scale to indicate how your health is **TODAY**.



# Oswestry Disability Index (ODI) v2

These questions are designed to give us information about your **low back or leg problem**. **Please move on to the next page if you do not have a low back or leg problem.** Mark **ONE** box only in each section that **most closely describes you over the last month**. Please answer as much as possible.

**Section 1 – Pain Intensity**
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**Section 2 – Personal Care (washing, dressing, etc.)**
- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 everyday in most aspects of self-care.
- ☐ I do not get dressed, 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, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only 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 100 yards.
- ☐ I can walk only with 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 sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 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 me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

**Section 7 – Sleeping**
- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours of sleep.
- ☐ Because of pain I have less than 4 hours of sleep.
- ☐ Because of pain I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

**Section 8 – Sex Life (if applicable)**
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

**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, e.g. sports, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

**Section 10 – Traveling**
- ☐ I can travel anywhere without 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 of less than one hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

# Neck Disability Index (NDI)

These questions are designed to give us information about your **neck or arm problem**. **Please move on to the next page if you do not have a neck or arm problem.** Mark **ONE** box only in each section that **most closely describes you over the last month**. Please answer as much as possible.

**Section 1 – Pain Intensity**
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**Section 2 – Personal Care (washing, dressing, etc.)**
- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 everyday in most aspects of self-care.
- ☐ I do not get dressed, 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, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can mange light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4 – Reading**
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

**Section 5 – Headaches**
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all of the time.

**Section 6 – Work**
- ☐ I can do as much work as I want to.
- ☐ I can do my usual work but no more.
- ☐ I can do most of my usual work but no more.
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

**Section 7 – Concentration**
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

**Section 8 – Driving (if applicable)**
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck pain.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

**Section 9 – Sleeping**
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

**Section 10 – Recreation**
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some neck pain.
- ☐ I am able to engage in most but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in few of my recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

## This Section Is For Post Intervention / Operative Patients Only

**Interval after surgery (please circle):**

3 Months  6 Months  1 Year  2 Years

**Did the intervention / surgery meet your expectations?**

Yes all  Yes some  No  Not applicable

**Overall, how much did the intervention / surgery in our hospital help your problem?**

Helped a lot  Helped  Helped a little  Didn't help  Made things worse

**Would you have the intervention / surgery again?**

Yes  No  Not applicable

**Please rate your % improvement in neck / back pain following the intervention / surgery**

<25  26-75  >76

**Please rate your % improvement in arm / leg pain following the intervention / surgery**

<25  26-75  >76

**Did any complications arise as a consequence of your intervention / surgery in our hospital (e.g. problems with wound healing, paralysis, sensory disturbances)?**

No  Yes - please describe: ……

**How bothersome were these complications?**

Not  Slightly  Moderate  Very  Extremely

**Since the intervention / surgery in our hospital, have you had any further operation(s) on your spine in our or in other hospitals?**

No  Yes but at a different level / part of spine  Yes at the same level

**Over the course of treatment for your spinal problem, how satisfied were you with your overall medical care in our hospital?**

Very satisfied  Somewhat satisfied  Ambivalent  Dissatisfied  Very dissatisfied

**Are your daily activities restricted because of your spinal problem?**

Yes great  Yes some  Not restricted

**How much pain medication do you require for your spinal problem?**

Regular  As required  None

**Did you return to employment / work?**

No  Yes limited  Yes full  Not applicable

**Thank you for your time completing this questionnaire.**