Mr M J H McCarthy
Consultant Spinal Surgeon

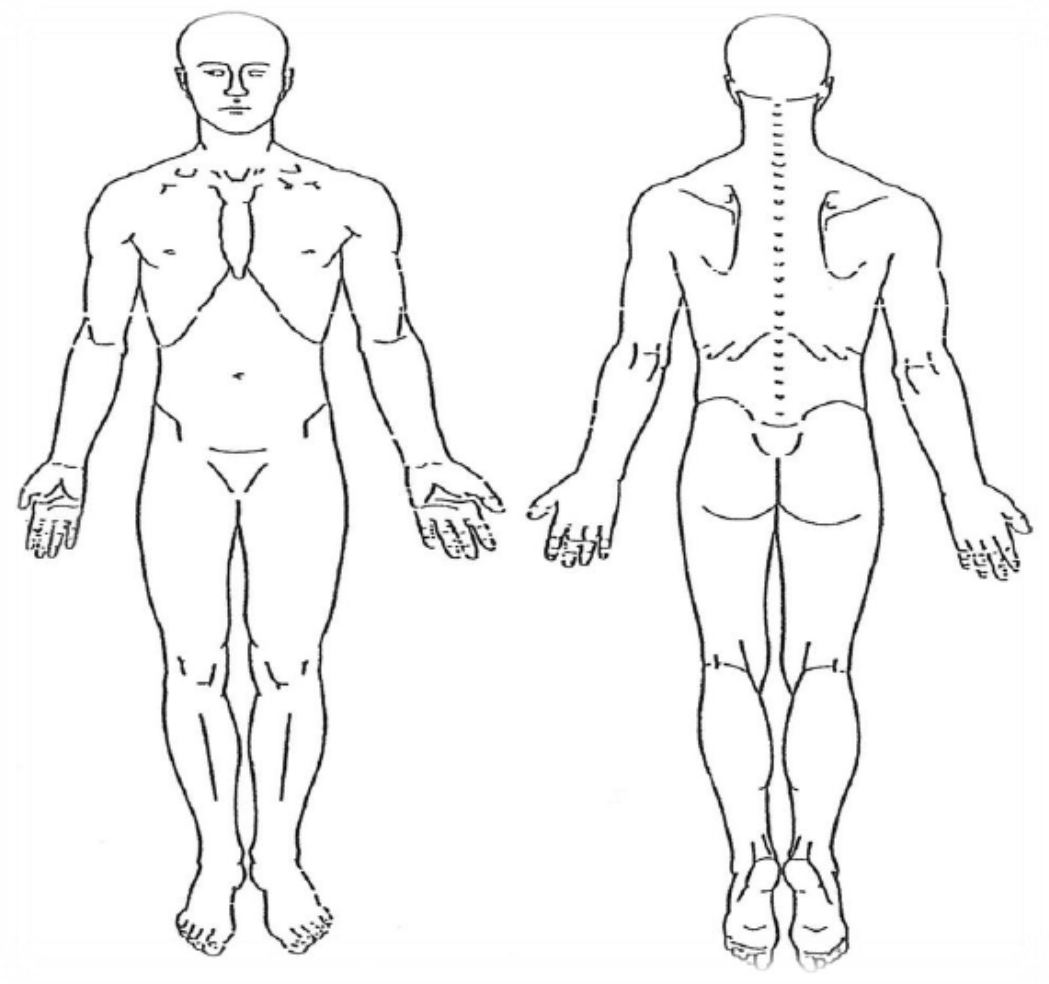
Affix Patient Label

Low Back / Leg Questionnaire

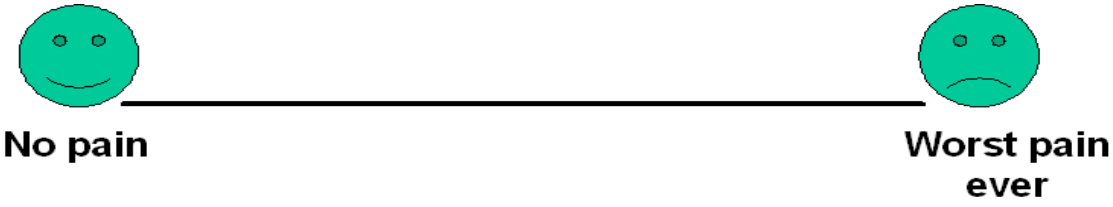
This document contains a series of standard assessments that are very useful in helping us assess your spinal problem. The questions also help to determine whether or not there has been any benefit from the treatments you have received.

Todays Date:

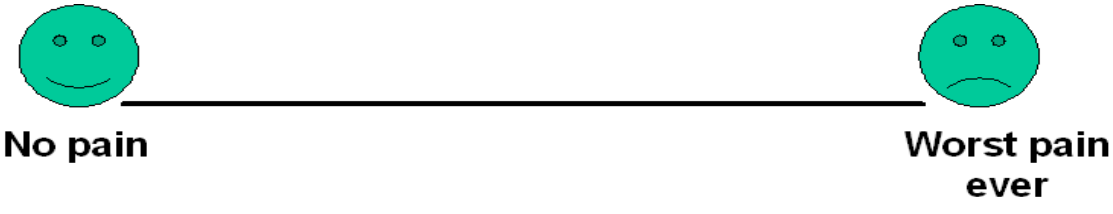
Where is your pain / problem located? Please shade the pain / problem areas on the diagram and mark the worst affected area.



Please mark a point on the line between the faces to indicate how much **BACK PAIN** you have felt **OVER THE LAST MONTH**.



Please mark a point on the line between the faces to indicate how much **LEG PAIN** you have felt **OVER THE LAST MONTH.**



PLEASE ANSWER BY CIRCLING THE WORDS THAT BEST FIT YOUR PROBLEM. YOU DO NOT HAVE TO COMPLETE THIS PAGE IF YOU HAVE DONE SO IN THE LAST YEAR.

Which of these problems is the worst for you?

Back pain Leg / buttock pain Sensory disturbances None of these

How far can you walk before you have to stop because of your problem?

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

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

Have you had previous spine surgery? Yes No

Does the problem affect your sleep? Yes No

Do you smoke? Yes No

What is your current 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

Are you receiving disability benefit? Yes No

Is there any personal injury claim pending regarding your back pain? Yes No

Have you had to retire because of your back? 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 ❑

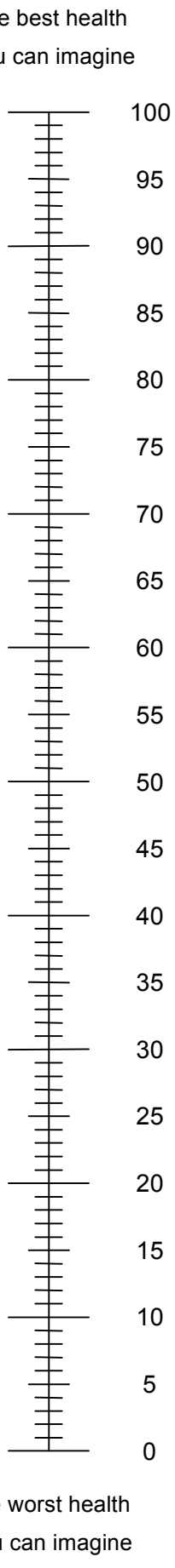
We would like to know how good or bad your health is **TODAY**.

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

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble has affected your **ability to manage in everyday life**. Please answer as much as possible. Mark **ONE** box only in each section that **most closely describes you over the last month**.

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 favorite 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 under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(*For office coding: Total Score* _____ = ___ + ___ + ___)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Spinal Expectations

Please circle the number that best describes your response to each question. How much improvement do you expect to find in the following areas as a result of the treatment for your spinal condition? **YOU DO NOT HAVE TO COMPLETE THIS PAGE IF YOU HAVE DONE SO IN THE LAST YEAR.**

	Back to normal / complete improvement	Not back to normal but			I do not have this expectation / not applicable to me
		A lot of improvement	A moderate improvement	A little improvement	
Relieve pain	4	3	2	1	0
Relieve symptoms that interfere with sleep	4	3	2	1	0
Improve ability to walk more than several streets	4	3	2	1	0
Improve ability to sit more than half an hour	4	3	2	1	0
Improve ability to stand more than half an hour	4	3	2	1	0
Regain strength in legs	4	3	2	1	0
Improve balance	4	3	2	1	0
Improve ability to go up and down stairs	4	3	2	1	0
Improve ability to manage personal care (wash and dress)	4	3	2	1	0
Improve ability to drive	4	3	2	1	0
Remove the need for pain medications	4	3	2	1	0
Improve ability to interact with others (social and family activities)	4	3	2	1	0
Improve sexual activity	4	3	2	1	0
Improve ability to perform daily activities (chores, shopping, errands)	4	3	2	1	0
Improve ability to exercise for general health	4	3	2	1	0
Remove restrictions in activities (be more mobile / not have to rest every few minutes)	4	3	2	1	0
If currently employed: fulfil job responsibilities	4	3	2	1	0
If currently work-disabled or unemployed: Go back to work / salaried employment	4	3	2	1	0
Reduce emotional stress or sad feelings	4	3	2	1	0
Stop my spine condition from getting worse	4	3	2	1	0
Remove the control my spine condition has on my life	4	3	2	1	0

This Section Is For Post Intervention / Operative Patients Only

Please circle the answer that best applies to you:

Did the intervention / surgery meet your expectations (table above)?

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 back pain following the intervention / surgery

<25 26-75 >76

Please rate your % improvement in 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 / operation in our hospital, have you had any further operation(s) on your back 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 back problem, how satisfied were you with your overall medical care in our hospital?

Very satisfied Somewhat satisfied Ambivalent Dissatisfied Very dissatisfied

How far can you walk?

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

Are your daily activities restricted because of your back / leg pain?

Yes great Yes some Not restricted

How much pain medication do you require for your back / leg pain?

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.