

Spinal Outcomes Questionnaire

Back and Leg Pain

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.

Today's Date:

Interval after surgery (please circle):

Initial Consultation / Pre Op 6 Months 1 Year 2 Years

Which of these problems troubles you the most?

Back pain Leg / Buttock pain Sensory disturbances None of these

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

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

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 Over 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 Over 21 days

How far can you walk?

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

EQ5D

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

The best health you can imagine

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)

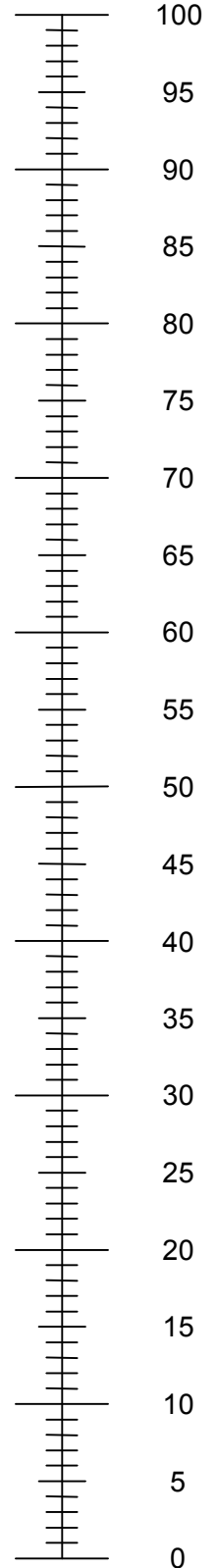
- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

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 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**.

The worst health you can imagine

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**.

| | |
|--|---|
| <p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. | <p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without extra pain. <input type="checkbox"/> I can stand as long as I want but it gives me extra pain. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> Pain prevents me from standing for more than ½ hour. <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> Pain prevents me from standing at all. |
| <p>Section 2 – Personal Care (washing, dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself without causing extra pain. <input type="checkbox"/> I can look after myself normally but it is very painful. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help everyday in most aspects of self-care. <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed. | <p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sleep is never disturbed by pain. <input type="checkbox"/> My sleep is occasionally disturbed by pain. <input type="checkbox"/> Because of pain I have less than 6 hours of sleep. <input type="checkbox"/> Because of pain I have less than 4 hours of sleep. <input type="checkbox"/> Because of pain I have less than 2 hours of sleep. <input type="checkbox"/> Pain prevents me from sleeping at all. |
| <p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift only very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. | <p>Section 8 – Sex Life (if applicable)</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sex life is normal and causes no extra pain. <input type="checkbox"/> My sex life is normal but causes some extra pain. <input type="checkbox"/> My sex life is nearly normal but is very painful. <input type="checkbox"/> My sex life is severely restricted by pain. <input type="checkbox"/> My sex life is nearly absent because of pain. <input type="checkbox"/> Pain prevents any sex life at all. |
| <p>Section 4 – Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me walking more than 1 mile. <input type="checkbox"/> Pain prevents me walking more than ½ mile. <input type="checkbox"/> Pain prevents me walking more than 100 yards. <input type="checkbox"/> I can walk only with a stick or crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. | <p>Section 9 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and gives me no extra pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out as often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have no social life because of pain. |
| <p>Section 5 – Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting for more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting for more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes. <input type="checkbox"/> Pain prevents me from sitting at all. | <p>Section 10 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without pain. <input type="checkbox"/> I can travel anywhere but it gives extra pain. <input type="checkbox"/> Pain is bad but I manage journeys over two hours. <input type="checkbox"/> Pain restricts me to journeys of less than one hour. <input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes. <input type="checkbox"/> Pain prevents me from traveling except to receive treatment. |

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?

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

Less than 25% 26-75% More than 76%

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

Less than 25% 26-75% More than 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 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

Thank you for your time completing this questionnaire.