

Spinal Outcomes Questionnaire

Neck and Arm 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 6 Months 1 Year 2 Years

Which of these problems troubles you the most?

Neck pain Arm / Shoulder pain Sensory disturbances None of these

On a scale of 0 to 10, how much neck 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 / shoulder 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)

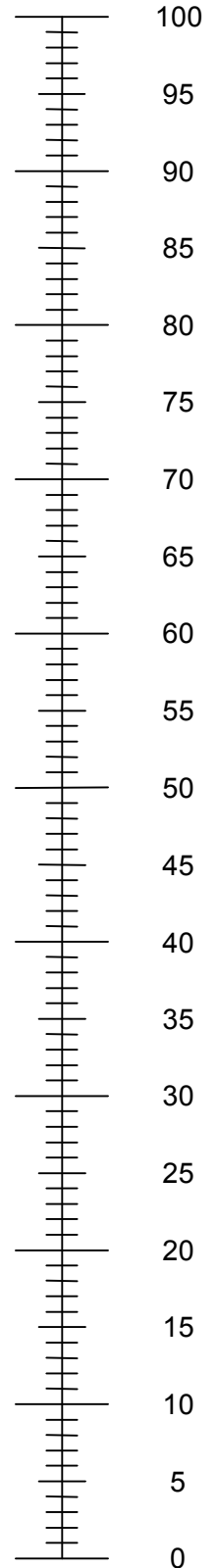
- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

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

Neck Disability Index (NDI)

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

<p>Section 1 – Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p>Section 6 – Work</p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can do my usual work but no more.</p> <p><input type="checkbox"/> I can do most of my usual work but no more.</p> <p><input type="checkbox"/> I cannot do my usual work</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I can't do any work at all.</p>
<p>Section 2 – Personal Care (washing, dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it is very painful.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help everyday in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</p>	<p>Section 7 – Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p>Section 3 – Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</p> <p><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.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift only very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>Section 8 – Driving (if applicable)</p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck</p> <p><input type="checkbox"/> I can't drive my car at all.</p>
<p>Section 4 – Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p>Section 9 – Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs sleepless).</p>
<p>Section 5 – Headaches</p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches that come frequently.</p> <p><input type="checkbox"/> I have severe headaches that come frequently.</p> <p><input type="checkbox"/> I have headaches almost all of the time.</p>	<p>Section 10 – Recreation</p> <p><input type="checkbox"/> I am able to engage in all my recreational activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with some neck pain.</p> <p><input type="checkbox"/> I am able to engage in most but not all of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I can't do any recreational activities at all.</p>

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 neck pain following the intervention / surgery

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

Please rate your % improvement in arm / shoulder 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 neck 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 neck 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.