

ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C.

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

Created: 9/25/03

Patient Name _____ 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

- 1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
 None Moderate to severe
 Mild Severe
 Moderate
- 2. Which one of the following best describes the amount of pain you have experienced over the last month?
 None Moderate to severe
 Mild Severe
 Moderate
- 3. During the past 6 months have you been a very nervous person?
 None of the time Most of the time
 A little of the time All of the time
 Some of the time
- 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?
 Very happy Somewhat unhappy
 Somewhat happy Very unhappy
 Neither happy nor unhappy
- 5. What is your current level of activity?
 Bedridden/wheelchair
 Primarily no activity
 Light labor, such as household chores
 Moderate manual labor and moderate sports, such as walking and biking
 Full activities without restriction
- 6. How do you look in clothes?
 Very good
 Good
 Fair
 Bad
 Very bad

- 7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
 Very often Rarely
 Often Never
 Sometimes
- 8. Do you experience back pain when at rest?
 Very often Rarely
 Often Never
 Sometimes
- 9. What is your current level of work/school activity?
 100% normal 25% normal
 75% normal 0% normal
 50% normal
- 10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
 Very good Poor
 Good Very poor
 Fair
- 11. Which one of the following best describes your medication usage for your back?
 None
 Non-narcotics weekly or less (e.g., Tylenol, Ibuprofen)
 Non-narcotics daily
 Narcotics weekly or less (e.g., Percocet, Lorcet, Codeine, Darvocet)
 Narcotics daily
 Other (please specify below)
Medication: _____
Usage (weekly or less or daily): _____

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

Patient Name _____ Date _____

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

