Patient Name_________________________

Dear Patient:

The following questions will help us tell how your back and/or neck is doing. Please answer all the questions to the best of your ability.

You may give the completed questionnaire to the Receptionist or Medical Assistant. Thank you in advance for your cooperation.

Please indicate the amount of time since your surgery:

6 weeks ____ 3 months ____ 6 months ____ 1 year ____

2 years ____ 3 years ____ 4 years ____ 5 years _____

HEALTH STATUS QUESTIONNAIRE (SF-36)

The following questions refer to your health in general, including, but not limited to, your back or neck.

1. In general, would you say your health is: (mark only one)

   O Excellent O Very Good O Good O Fair O Poor

2. **Compared to one year ago,** how would you rate your health in general **now**? (mark only one)

   O Much better than 1 year ago O Somewhat better than 1 year ago O About the same as 1 year ago O Somewhat worse than 1 year ago O Much worse than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Fill in only one circle on each line.)

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited
3. **Vigorous activities** such as running, lifting heavy objects or participating in strenuous sports.	O	O	O
4. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling or golf.	O	O	O
5. Lifting or carrying groceries.	O	O	O
6. Climbing **several** flights of stairs.	O	O	O
7. Climbing **one** flight of stairs.	O	O	O
8. Bending, kneeling, or stooping.	O	O	O
9. Walking **more than a mile**.	O	O	O
10. Walking **several blocks**.	O	O	O
11. Walking **one block**.	O	O	O
12. Bathing or dressing yourself	O	O	O

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Fill in only one circle on each line.)

	Yes	No
13. Cut down on the **amount of time** you spent on work or other activities.	O	O
14. **Accomplished less** than you would like.	O	O
15. Were limited in the **kind** of work or other activities.	O	O
16. Had difficulty performing the work or other activities (e.g. took extra effort)	O	O

During the **past 4 weeks**, have you had any of the following problems with your regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Fill in only one circle on each line.)

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities?	O	O
18. **Accomplished less** than you would like?	O	O
19. Didn’t do work or other activities as **carefully** as usual?	O	O

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (mark only one)
    O Not at all O Slightly O Moderately O Quite a bit O Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**? (mark only one)
    O None O Very Mild O Mild O Moderate O Severe O Very Severe

22. During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and housework)? (mark only one)
    O Not at all O A little bit O Moderately O Quite a bit O Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much time **during the past 4 weeks**… (Fill in only one circle on each line.)

	All of the Time	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
23. Did you feel full of pep?	O	O	O	O	O	O
24. Have you been a very nervous person?	O	O	O	O	O	O
25. Have you felt so down in the dumps that nothing could cheer you up?	O	O	O	O	O	O
26. Have you felt calm and peaceful?	O	O	O	O	O	O
27. Did you feel full of energy?	O	O	O	O	O	O
28. Have you felt downhearted and blue?	O	O	O	O	O	O
29. Did you feel worn out?	O	O	O	O	O	O
30. Have you been a happy person?	O	O	O	O	O	O
31. Did you feel tired?	O	O	O	O	O	O

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends and relatives, etc.)? (mark only one)

    O All of the time O Most of the time O Some of the time O A little of the time O None of the time

How **TRUE** or **FALSE** is **each** of the following statements for you? (Fill in only one circle on each line.)

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
33. I seem to get sick a little easier than other people.	O	O	O	O	O
34. I am as healthy as anybody I know.	O	O	O	O	O
35. I expect my health to get worse.	O	O	O	O	O
36. My health is excellent.	O	O	O	O	O

OSWESTRY QUESTIONNAIRE

The following questions will give us information as to how your back or leg pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the answer which applies to you. We realize you may consider that two of the statements in any one section relate to you. Please just give the answer which most clearly describes your problem.

Pain Intensity (mark only one)
0. I have no pain at this moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.) (mark only one)
0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it is very painful.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, wash with difficulty, and stay in bed.

Lifting (mark only one)
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives me extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

Walking (mark only one)
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking for more than 1 mile.
2. Pain prevents me from walking for more than 1/4 mile.
3. Pain prevents me from walking for more than 100 yards.
4. I can only walk using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

Sitting (mark only one)
0. I can sit in any chair as long as I like.
1. I can sit in my favorite chair as long as I like.
2. Pain prevents me from sitting for more than 1 hour.
3. Pain prevents me from sitting for more than 1/2 hour.
4. Pain prevents me from sitting for mores than 10 minutes.
5. Pain prevents me from sitting at all.

Standing (mark only one)
0. I can stand as long as I want without extra pain.
1. I can stand as long as I want, but it gives me extra pain.
2. Pain prevents me from standing for more than one hour.
3. Pain prevents me from standing for more than 1/2 hour.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Sleeping (mark only one)
0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed pain.
2. Because of pain I have less than 6 hours sleep.
3. Because of pain I have less than 4 hours sleep.
4. Because of pain I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

Sex Life (mark only one)
0. My sex life is normal and causes no extra pain.
1. My sex life is normal, but causes some extra pain.
2. My sex life is nearly normal, but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Social Life (mark only one)
0. My social life is normal and gives me no extra pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. sports, etc.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have no social life because of pain.

Traveling (mark only one)
0. I can travel anywhere without extra pain.
1. I can travel anywhere, but it gives me extra pain.
2. Pain is bad, but I manage journeys over two hours.
3. Pain restricts me to journeys of less than one hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from traveling except to receive treatment.

BACK AND LEG PAIN QUESTIONNAIRE

This form is for the purpose of collecting back pain and leg pain information from you. Answer **every** question by filling in the appropriate circle. If you are unsure about how to answer a question, please give the best answer you can. Mark only **one** answer for each question.

BACK PAIN

1. On the scale of 0 to 10, mark your intensity of **back** pain discomfort with 0 being **no pain** and 10 being p**ain as bad as it could be.**

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad As It Could Be**
	O	O	O	O	O	O	O	O	O	O	O	

2. On the scale of 0 to 10, mark how often you had **back** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	**All Of The Time**
	O	O	O	O	O	O	O	O	O	O	O	

LEG PAIN

1. On the scale of 0 to 10, mark your intensity of **leg** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad As It Could Be**
	O	O	O	O	O	O	O	O	O	O	O	

2. On the scale of 0 to 10, mark how often you had **leg** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	**All Of The Time**
	O	O	O	O	O	O	O	O	O	O	O	

POSTOPERATIVE PATIENT SURVEY

1. Do you smoke or use tobacco?
   - O Yes, I use tobacco
   - O Never smoked or used tobacco
   - O No, quit in last 6 months
   - O No, quit over 6 months ago

2. Do you currently use alcohol?
   - O Yes
   - O No

PAIN OR MUSCLE RELAXANT MEDICATION REGIMEN

During the last week, how often have you taken the following for your back/leg pain or neck/arm pain:

3. Non-Narcotic medication (such as aspirin, Tylenol, Motrin, Vioxx, Celebrex)
   - O 3 or more times a day
   - O Once or twice a day
   - O Once every couple of days
   - O Once a week
   - O Not at all

4. Weak narcotic medication (such as Tylenol #3, Darvocet N-100, Darvon, Vicodin)
   - O 3 or more times a day
   - O Once or twice a day
   - O Once every couple of days
   - O Once a week
   - O Not at all

5. Strong narcotic medication (such as Percodan, Percocet, Morphine, Demerol)
   - O 3 or more times a day
   - O Once or twice a day
   - O Once every couple of days
   - O Once a week
   - O Not at all

6. Muscle Relaxant medication (such as Flexeril, Parafon Forte, Robaxin)
   - O 3 or more times a day
   - O Once or twice a day
   - O Once every couple of days
   - O Once a week
   - O Not at all

PATIENT SATISFACTION:	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
7. I am satisfied with the results of my surgery.	O	O	O	O	O
8. I was helped as much as I thought I would be by my surgery.	O	O	O	O	O
9. All things considered, I would have the surgery again for the same condition.	O	O	O	O	O

10. **PERCEIVED EFFECT OF SURGICAL TREATMENT:**
    - O Completely Recovered
    - O Much Improved
    - O Slightly Improved
    - O No Change
    - O Slightly Worsened
    - O Much Worsened
    - O Vastly Worsened

WORK STATUS:

1. Have you returned to work? O Yes O No O Was not working prior to surgery/Not applicable

   If yes, please answer the following:

   a. Date returned to work: __ __/__ __/__ __ __ __
      (Disregard date returned to work if completed on prior form)

   b. Occupation: ______________________________

   c. O Full Time O Part Time
      O Full Duty O Light Duty

   d. If you are working less than **Full Time** or **Full Duty**, is this because of the problems with your back/neck?
      O Yes O No

   If no, is this because of the problems with your back/neck?
      O Yes O No

2. Is your current job the same as when your back/neck problems began?
   - O Yes, exact same job.
   - O No, job changed due to back problems.
   - O Yes, but job was lightened due to back problems.
   - O No, job changed for reasons other than back.
   - O Not currently working.