



Samuel K. Cho, M.D.
Spinal Deformity Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Exam: Pre-treatment 6 wks. 3 mos. 6 mos. 1 year \_\_\_\_\_ years

Please read the instructions:

This questionnaire has been designed to give the doctor information as to how your overall health and back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Scoliosis Research Society Questionnaire

SECTION 1 – ALL PATIENTS

- 1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
2. Which one of the following best describes the amount of pain you have experienced over the last month?
3. During the past 6 months have you been a very nervous person?
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?
5. What is your current level of activity?
6. How do you look in clothes?
7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
8. Do you experience back pain when at rest?
9. What is your current level of work/school activity?
10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
11. Which one of the following best describes your medication usage for your back?
12. Does your back limit your ability to do things around the house?

- 13. Have you felt calm and peaceful during the past 6 months?
14. Do you feel that your back condition affects your personal relationships?
15. Are you and/or your family experiencing financial difficulties because of your back?
16. In the past 6 months have you felt downhearted and blue?
17. In the last 3 months have you taken any sick days from work/school due to back pain and, if so, how many?
18. Do you go out more or less than your friends?
19. Do you feel attractive with your current back condition?
20. Have you been a happy person during the past 6 months?
21. Are you satisfied with the results of your back management?
22. Would you have the same management again if you had the same condition?
23. On a scale of 1 to 9, with 1 being very low and 9 being extremely high, how would you rate your self-image?

SECTION 2 – POST-SURGERY PATIENTS ONLY

- 24. Compared with before treatment, how do you feel you now look?
25. Has your back treatment changed your function and daily activity?
26. Has your back treatment changed your ability to enjoy sports/hobbies?
27. Has your back treatment \_\_\_\_\_ your back pain?
28. Has your treatment changed your confidence in personal relationships with others?
29. Has your treatment changed the way others view you?
30. Has your treatment changed your self-image?

**Modified Oswestry Disability Index****SECTION 1 – PAIN INTENSITY**

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain, I do not use them.

**SECTION 2 – PERSONAL CARE (washing, dressing, etc.)**

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- 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 every day in most aspects of self care.
- I do not get dressed; I 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, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift 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 ¼ mile.
- I can only walk using 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 only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than thirty minutes.
- Pain prevents me from sitting more than ten 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 extra pain.
- Pain prevents me from standing more than one hour.
- Pain prevents me from standing more than thirty minutes.
- Pain prevents me from standing more than ten minutes.
- Pain prevents me from standing at all.

**SECTION 7 – SLEEPING**

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than six hours sleep.
- Even when I take tablets I have less than four hours sleep.
- Even when I take tablets I have less than two hours sleep.
- Pain prevents me from sleeping at all.

**SECTION 8 – EMPLOYMENT/HOMEMAKING**

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities like lifting, vacuuming, etc.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

**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 like dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to home.
- I have no social life because of pain.

**SECTION 10 – TRAVELING**

- I can travel anywhere without extra 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 less than one hour.
- Pain restricts me to short journeys under thirty minutes.
- Pain prevents me from traveling except to the doctor or hospital.

**General Health Status Questionnaire**

- In general, would you say your health is... (Mark only one)  
 Excellent  Very Good  Good  Fair  Poor
- Compared to one year ago**, how would you rate your health in general **now**? (Mark only one)  
 Much better  Somewhat better  About the same  Somewhat worse  Much worse

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 At All
3. <b>Vigorous activities</b> such as running, lifting heavy objects, or participating in strenuous sports.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. <b>Moderate activities</b> such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Lifting or carrying groceries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Climbing <b>several</b> flights of stairs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Climbing <b>one</b> flight of stairs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Bending, kneeling, or stooping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Walking <b>more than a mile</b> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Walking <b>several blocks</b> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Walking <b>one block</b> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Bathing or dressing yourself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 the <b>amount of time</b> you spent on work or other activities.	<input type="radio"/>	<input type="radio"/>
14. <b>Accomplished less</b> than you would like.	<input type="radio"/>	<input type="radio"/>
15. Were limited in the <b>kind</b> of work or other activities.	<input type="radio"/>	<input type="radio"/>
16. Had <b>difficulty</b> performing the work or other activities (e.g., it took extra effort).	<input type="radio"/>	<input type="radio"/>

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 any emotional problems** (such as feeling depressed or anxious)? (Fill in only one circle on each line)

	Yes	No
17. Cut down the <b>amount of time</b> you spent on work or other activities.	<input type="radio"/>	<input type="radio"/>
18. <b>Accomplished less</b> than you would like.	<input type="radio"/>	<input type="radio"/>
19. Didn't do work or other activities as <b>carefully</b> as usual.	<input type="radio"/>	<input type="radio"/>

- 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)  
 Not at all  Slightly  Moderately  Quite a bit  Extremely

- How much **bodily** pain have you had during the **past 4 weeks**? (Mark only one)  
 None  Very mild  Mild  Moderate  Severe  Very severe

- During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and house work)? (Mark only one)  
 Not at all  A little bit  Moderately  Quite a bit  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 (happy)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Have you been a very nervous person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Have you been a happy person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- 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, relative, etc.)? (Mark only one)  
 Not at all  A little bit  Moderately  Quite a bit  Extremely

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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. I am as healthy as anybody I know.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. I expect my health to get worse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. My health is excellent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>