Scoliosis Research Society's Scoliosis Patient Questionnaire

Patient Name: ___________________________ Age: ___________ Date: ____________

Medical Record #: ________________________ SS#: ______________________________

Surgery date: ____________________________ Follow-up: _________________________

We are carefully evaluating the condition of your back. Please circle the best answer to each question unless otherwise indicated.

1. On a scale of 1 to 9, with 1 meaning "no pain" and 9 meaning "severe pain", Indicate the degree of pain you experience regularly

   1 2 3 4 5 6 7 8 9

2. Using the same scale, indicate the most severe degree of pain you have experienced over the last month.

   1 2 3 4 5 6 7 8 9

3. If you had to spend the rest of your life with your back as it is right now, how would you feel about it?

   Very happy
   Somewhat happy
   Neither happy nor unhappy
   Somewhat unhappy
   Very unhappy

4. 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

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5. How do you look in clothes?

Very good
Good
Fair
Bad
Very bad

6. Do you experience back pain when at rest?

Very often
Often
Sometimes
Rarely
Never

7. What is your current level of work/school activity?

100% normal
75% normal
50% normal
25% normal
0% normal

8. What medications, if any, are you currently taking for your back? (circle all that apply)

None
Non-steroidals (i.e. Motrin)
Steroids (cortisone)
Muscle Relaxants (Valium)
Narcotics (Morphine)

9. Does your back limit your ability to do things around the house?

Yes No

10. Have you taken any sick days from work/school due to back pain?

Yes No

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11. Do you feel your condition affects your personal relationships?

    Yes No

12. Are you and/or your family experiencing financial difficulties because of your back?

    None Some A lot

13. Do you go out more or less than your friends?

    More Same Less

14. Do you feel attractive?

    Yes, very
    Yes, somewhat
    Neither attractive nor unattractive
    No, not very much
    No, not at all

15. On a scale of 1 to 9, with one being very low and 9 being extremely high how would you rate your self-image?

    1 2 3 4 5 6 7 8 9

16. Has your back treatment changed your function or daily activity?

    Increased Not changed Decreased

17. Has your back treatment changed your ability to enjoy sports/hobbies?

    Increased Not changed Decreased

18. Has your treatment ___________ your back pain?

    Increased Not changed Decreased

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19. Has your treatment changed your confidence in personal relationships with others?

    Increased Not changed Decreased

20. Has your treatment changed the way others view you?

    Much better
    Better
    Same
    Worse
    Much worse

21. Has your treatment changed your self-image?

    Increased Not changed Decreased

22. Are you satisfied with the results of your back treatment?

    Extremely satisfied
    Somewhat satisfied
    Neither satisfied nor dissatisfied
    Somewhat dissatisfied
    Extremely dissatisfied

23. Compared to before your treatment, how do you feel you now look?

    Much better
    Better
    Same
    Worse
    Much worse

24. Would you have the same treatment again if you had the same condition?

    Definitely yes
    Probably yes
    Not sure
    Probably not
    Definitely not

Thank you for completing this questionnaire.

End

Scoliosis Research Society's Scoliosis Patient Questionnaire: Score Sheet

Name: ____

Diagnosis: ____

Date: ________________________ Interval ____________________________

Domain	Score Pt/Possible (Max) a a`	# Question Answered(Poss) b	Mean a÷b
Pain _____ _____ _____ _____ _____ _____ _____ (1*, 2, 3, 6, 8, 11, 18)	___/___(35)	___(7)	___.___
General self-image _____ _____ _____ (5, 14, 15)	___/___(15)	___(3)	___.___
Self-image after surgery _____ _____ _____ (19, 20, 21)	___/___(15)	___(3)	___.___
Function after surgery _____ _____ (16, 17)	___/___(10)	___(2)	___.___
General function _____ _____ _____ (7, 12, 13)	___/___(15)	___(3)	___.___
Function-activity _____ _____ _____ (4, 9, 10)	___/___(15)	___(3)	___.___
Satisfaction with surgery _____ _____ _____ (22, 23, 24)	___/___(15)	___(3)	___.___
TOTAL	___/___(120)	___(24)	___.___ Mean Score

a/a` X 100= (%)
100% Best
20% Worst

Mean Score: 5 Best, 1 Worst

* Question number