

Mr M J H McCarthy
Consultant Spinal Surgeon
Patient Reported Outcome Measures

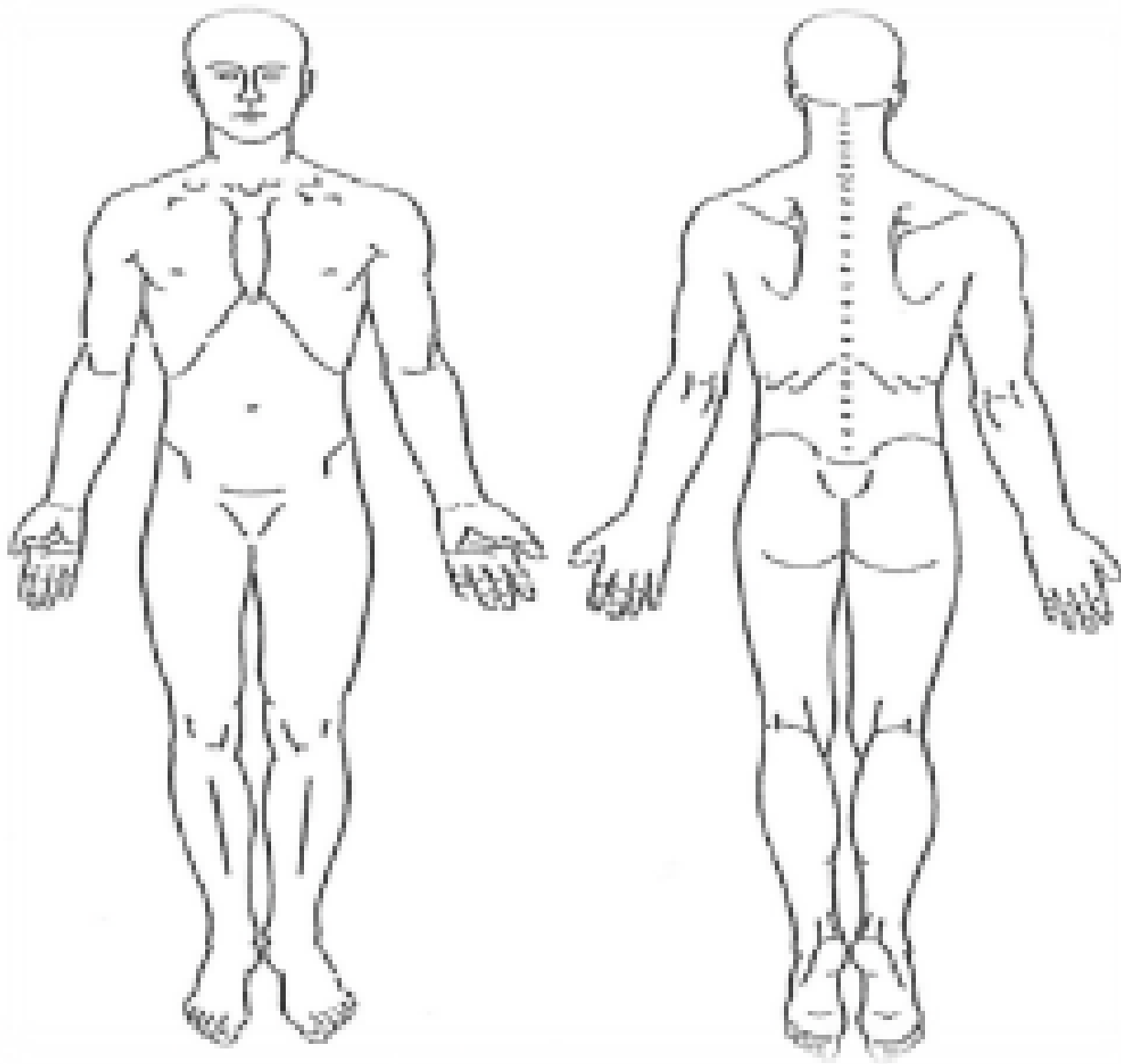
Today's Date:

Date of Birth:

ID Number:

Where is your pain / problem located?

Please tick the pain / problem areas on the diagram.



On a scale of 0 to 10, how much neck / back 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 / leg pain have you felt over the last month?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PLEASE ANSWER BY SELECTING THE WORDS THAT BEST FIT YOUR PROBLEM

Which of these problems is the worst for you?

Neck / Low Back pain Arm / Leg pain Sensory changes Other

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 >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 >21 days

How far can you walk?

100 yards 200 yards 400 yards 800 yards 1 mile or more

What is your current work status? E.g. Student, housewife, working, retired, disabled

How much time have you lost from work in the last year?

None	less than a week	one to three weeks
three to six weeks	six to twelve weeks	three to six months
six to twelve months	more than one year	

Is there any personal injury claim pending regarding your spinal problem?

Yes No

Are you receiving disability benefit?

Yes No

Have you had to retire because of your spine?

Yes No

Have you had previous spinal surgery?

Yes No

Do you smoke?

Yes No

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

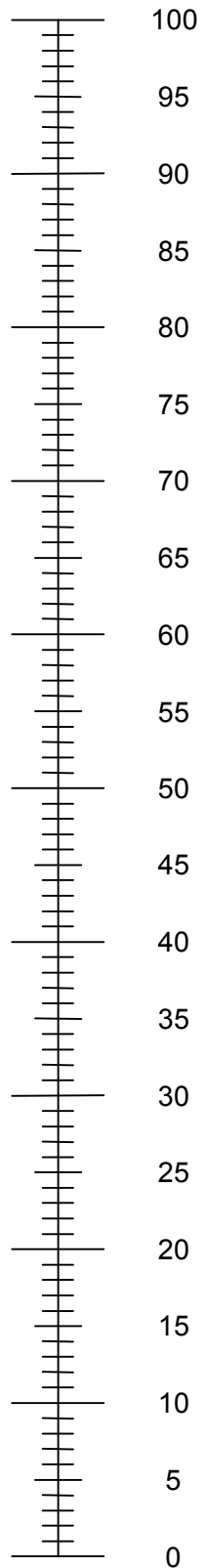
We would like to know how good or bad your health is **TODAY**.

The scale on the right 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

Oswestry Disability Index (ODI) v2

These questions are designed to give us information about your **low back or leg problem**. **Please move on to the next page if you do not have a low back or leg problem.** Mark **ONE** box only in each section that **most closely describes you over the last month**. Please answer as much as possible.

<p>Section 1 – Pain Intensity I have no pain at the moment. The pain is very mild at the moment. The pain is moderate at the moment. The pain is fairly severe at the moment. The pain is very severe at the moment. The pain is the worst imaginable at the moment.</p>	<p>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 me extra pain. Pain prevents me from standing for more than 1 hour. Pain prevents me from standing for more than ½ hour. Pain prevents me from standing for more than 10 minutes. Pain prevents me from standing at all.</p>
<p>Section 2 – Personal Care (washing, dressing, etc.) I can look after myself without causing extra pain. I can look after myself normally but it is very painful. 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 everyday in most aspects of self-care. I do not get dressed, wash with difficulty and stay in bed.</p>	<p>Section 7 – Sleeping My sleep is never disturbed by pain. My sleep is occasionally disturbed by pain. Because of pain I have less than 6 hours of sleep. Because of pain I have less than 4 hours of sleep. Because of pain I have less than 2 hours of sleep. Pain prevents me from sleeping at all.</p>
<p>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, e.g. on a table. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. I can lift only very light weights. I cannot lift or carry anything at all.</p>	<p>Section 8 – Sex Life (if applicable) My sex life is normal and causes no extra pain. My sex life is normal but causes some extra pain. My sex life is nearly normal but is very painful. My sex life is severely restricted by pain. My sex life is nearly absent because of pain. Pain prevents any sex life at all.</p>
<p>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 100 yards. I can walk only with a stick or crutches. I am in bed most of the time and have to crawl to the toilet.</p>	<p>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, e.g. sports, etc. Pain has restricted my social life and I do not go out as often. Pain has restricted my social life to my home I have no social life because of pain.</p>
<p>Section 5 – Sitting I can sit in any chair as long as I like. I can sit in my favourite chair as long as I like. Pain prevents me from sitting for more than 1 hour. Pain prevents me from sitting for more than ½ hour. Pain prevents me from sitting for more than 10 minutes. Pain prevents me from sitting at all.</p>	<p>Section 10 – Traveling I can travel anywhere without 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 of less than one hour. Pain restricts me to short necessary journeys less than 30 minutes. Pain prevents me from traveling except to receive treatment.</p>

Neck Disability Index (NDI)

These questions are designed to give us information about your neck or arm problem. **Please move on to the next page if you do not have a neck or arm problem.** Mark **ONE** box only in each section that most closely describes you over the last month. Please answer as much as possible.

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

PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

GAD-7

Over the last 2 weeks , how often have you been bothered by the following problems? <i>(Use “✓” to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

This Section Is For Post Injection / Operative Patients Only

Interval after injection / surgery:

3 Months

6 Months

1 Year

2 Years

Did the injection / surgery meet your expectations?

Yes all

Yes some

No

Not applicable

Overall, how much did the injection / surgery in our hospital help your problem?

Helped a lot

Helped

Helped a little

Didn't help

Made things worse

Would you have the injection / surgery again?

Yes

No

Not applicable

Please rate your % improvement in neck / back pain following the injection / surgery

<25

26-75

>76

Please rate your % improvement in arm / leg pain following the injection / surgery

<25

26-75

>76

Did any complications arise as a consequence of your injection / 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 injection / surgery in our hospital, have you had any further operation(s) on your spine 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 spinal problem, how satisfied were you with your overall medical care in our hospital?

Very satisfied

Somewhat satisfied

Ambivalent

Dissatisfied

Very dissatisfied

Are your daily activities restricted because of your spinal problem?

Yes great

Yes some

Not restricted

How much pain medication do you require for your spinal problem?

Regular

As required

None

Did you return to employment / work?

No

Yes limited

Yes full

Not applicable