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Thoraco-lumbar Fracture Employment Questionnaire

Thank you for taking part in this study and for taking time out of your day to complete this questionnaire. This questionnaire has been sent to patients who had a fracture in their thoracic or lumbar spine over 5 years ago. We want to improve our service and know the long-term outcome specifically with regards to employment. Once completed we would be very grateful if you could post the questionnaire back to us in the enclosed self-addressed envelope.

If you prefer to complete the questionnaire online then you can do so at www.spinedragon.com, follow the link to questionnaires and complete the thoraco-lumbar questionnaire. You will need to download the questionnaire onto your computer, complete it, save the completed file, and email it back to us. You will need to input your unique ID number shown above (or your date of birth). Please note, no data is stored on the website.

The answers to your questionnaire will be held on an anonymous encrypted database on NHS computers. Nobody will be able to identify you. The questionnaire is voluntary, and you do not have to participate. This will not affect the future care you receive. This questionnaire will only take 10 minutes to complete. If you have any questions, then our contact details can be found at the end of this questionnaire.

Unique ID number:

Date of Birth:

Employment:

1. Were you employed prior to your spinal fracture?

Yes

No

[If no go to question 5](#)

1.b) Prior to the injury what was your occupation?

1.c) Please specify how many hours you worked in a week

Hours

2. Following your injury did you return to the same occupation?

Yes

No

If not why

3. How much time did you receive off work?

4. Did you receive any specific advice from the medical team treating you about your return to work?

Yes

No

Please specify the advice

[Please go to question 6](#)

5. Was there any specific reasons for your unemployment prior to your injury?

Yes

No

If Yes, please specify (some examples are shown below):

long term pain, nerve problems, parent, student, ill health, job seeker, unpaid carer for ill relative, redundant

6. Are you currently employed?

Yes

No

[If no go to question 10](#)

What is your current occupation

How many hours do you work in a week?

Hours

È Regarding your return to work was your support sufficient?

Yes No

È Which of the following did you receive in regards to your return to work?

Phase return to work Amended duties
Altered hours Workplace adaptations
Other Please specify:

9. Which of the following would have helped you in your return to work?

Phase return to work Amended duties
Altered hours Workplace adaptations
Other Please specify:

[Please go to question 11](#)

10. Please tick the single best answer from the following why you could not return to work?

Physically impossible Pain
Retired Other Please specify

Treatment:

11. With regards to your spinal fracture, did you have an operation?

Yes No [If No please skip to question 14](#)

12. How long after your injury was the surgery performed?

On admission Within 2 weeks 2-6 weeks >6 weeks

13. Were there any complications with regards to your surgery?

Yes No

Please specify the complication:

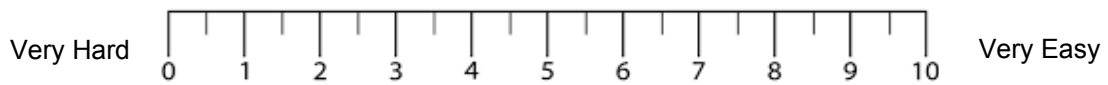
14. Were you given a spinal brace to wear regardless of surgery?

Yes

No

If No please skip to question 16

15. With regards to your spinal brace please mark below how easy it was to wear?



16. After your injury which of the following therapies/managements did you receive? (Please tick one or more below)

- Bladder or bowel management
- Pain/spasm management
- Social services/Employment assistance
- Physiotherapy/Occupational therapy
- Education on disorder

17. After your injury which of the following therapies/managements would you have wanted to receive? (Please tick one or more below)

- Bladder or bowel management
- Pain/spasm management
- Social services/Employment assistance
- Physiotherapy/Occupational therapy
- Education on disorder

Pain:

18. Prior to this injury did you have any pre-existing problems with your spine?

Yes

No

If No please skip to question 19

Please describe the Pre-existing problem:

19. Please tick the corresponding box for any **Pre**-existing back or leg pain before your injury?

Back

Leg

Both

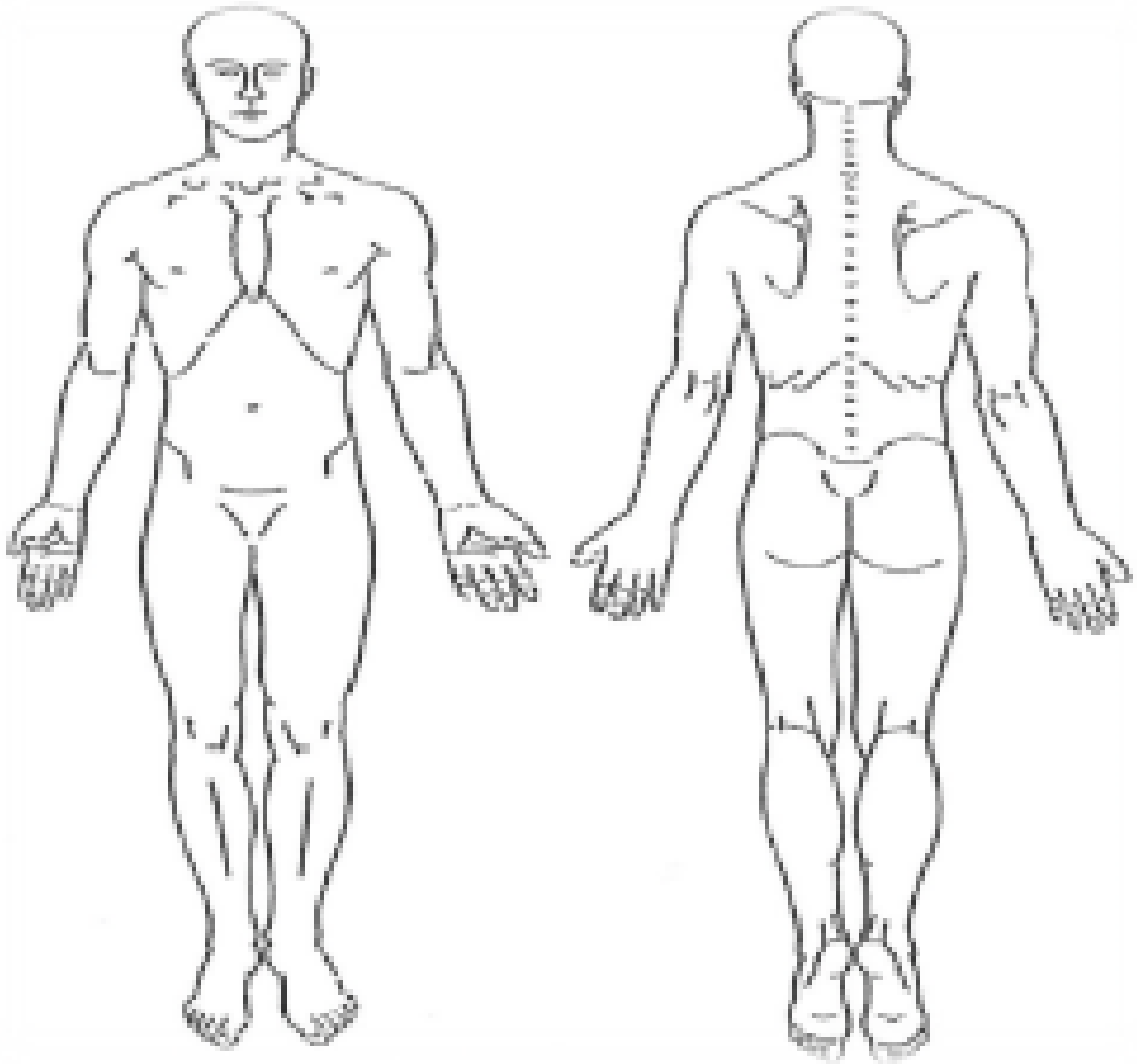
None

If None please skip to question 20

How long had this pain occurred for:

What medications did you take to alleviate this pain?

Please mark the area of your *pre-existing pain* on this diagram:



20. Please tick the corresponding box for any **On**-going back or leg pain after your injury?

Back

Leg

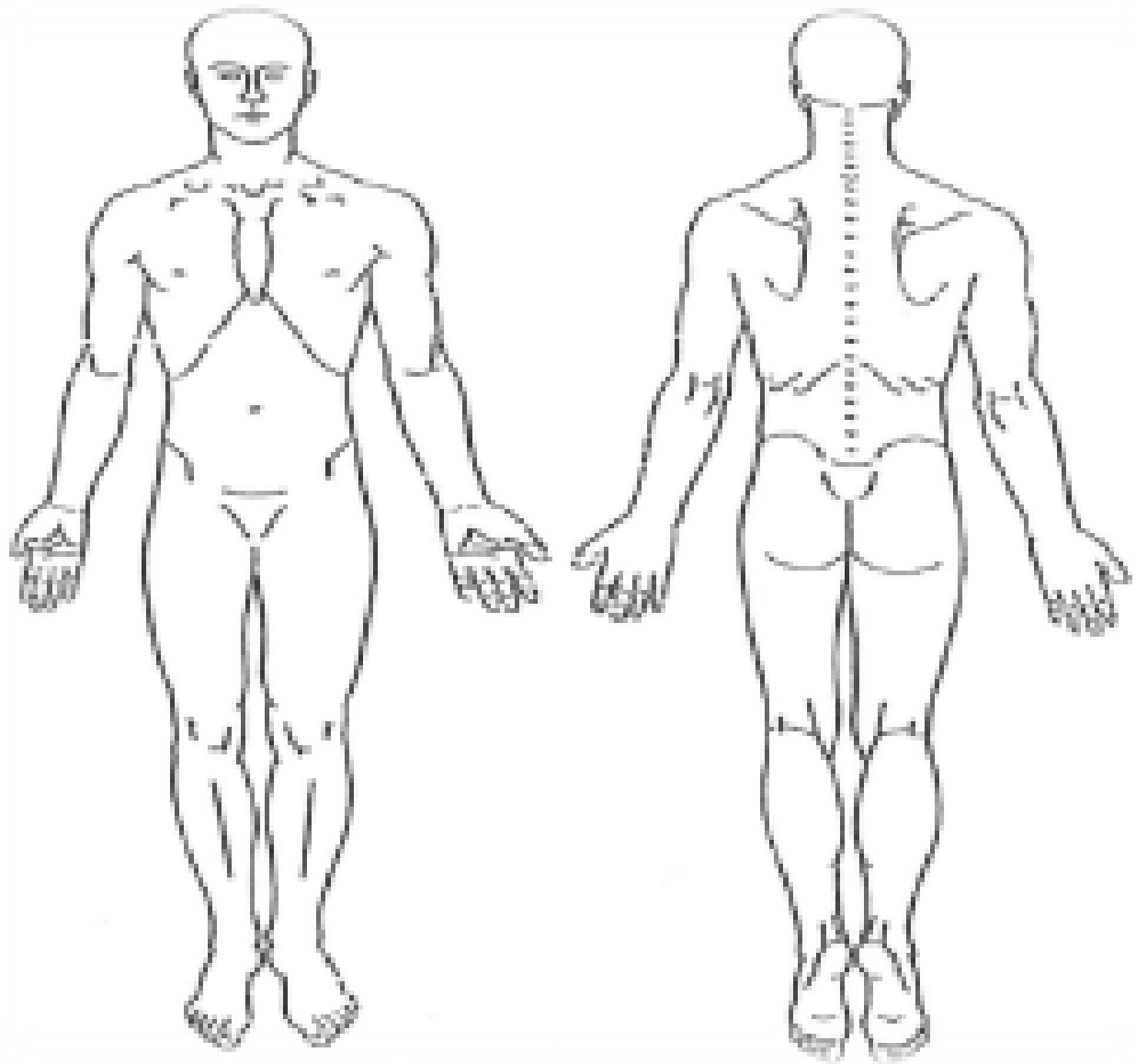
Both

None

[If None please skip to question 21](#)

What medications did you take to alleviate this pain?

Please mark the area of any *on-going pain* on this diagram:



Neurology:

Q21. Prior to your injury did you experience any Numbness, Tingling or Paralysis in your legs or back? (Please tick the corresponding boxes)

Back Left leg Right leg None

Q22. Prior to your injury did you have any weakness in the following movements? (Please tick the corresponding box)

Raising Leg	Left	Right	Both	None
Kicking Ball with bent Knee	Left	Right	Both	None
Raising foot with heel on the floor	Left	Right	Both	None
Pointing toe towards the sky	Left	Right	Both	None
Pressing foot on a car pedal	Left	Right	Both	None

Q23. Currently do you experience any Numbness, Tingling or Paralysis in your legs or back? (Please tick the corresponding boxes)

Back Left leg Right leg None

Q24. Currently do you have any weakness in the following movements? (Please tick the corresponding box)

Raising Leg	Left	Right	Both	None
Kicking Ball with bent Knee	Left	Right	Both	None
Raising foot with heel on the floor	Left	Right	Both	None
Pointing toe towards the sky	Left	Right	Both	None
Pressing foot on a car pedal	Left	Right	Both	None

Manual Activity and Abilities:

This section is about aspects of your life following your spinal injury. Please mark on the scales below your current level of function compared to before the accident.

0 indicates a level at which you are **NON-FUNCTIONAL**

100 indicates the level **BEFORE** the accident, no matter how well or poorly you functioned before the accident.

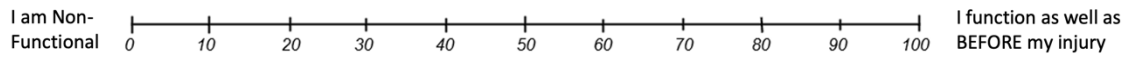
25. Household activities (such as cleaning in and around the house, doing laundry or preparing a meal)

I am Non-Functional 0 10 20 30 40 50 60 70 80 90 100 I function as well as BEFORE my injury

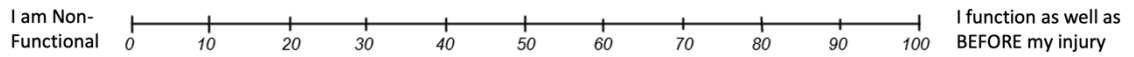
26. Work / study (if you were not working or studying BEFORE the accident, please skip this question)

I am Non-Functional 0 10 20 30 40 50 60 70 80 90 100 I function as well as BEFORE my injury

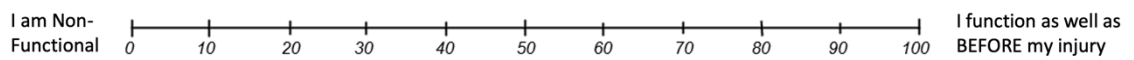
27. Recreation and leisure (such as hobbies or sports)



28. Social life (such as maintaining relationships with family, friends and acquaintances)



29. Walking (with or without an aid)



30. Travel (such as driving yourself, using public transportation or other means of transport)



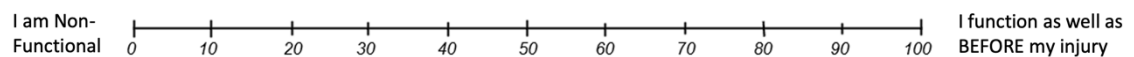
31. Changing posture (such as lying down, sitting or standing)



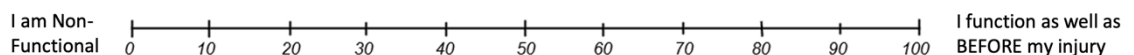
32. Maintaining posture (such as lying down, sitting or standing, for as long as



33. Lifting and carrying (such as lifting a bag of groceries or carrying a child)



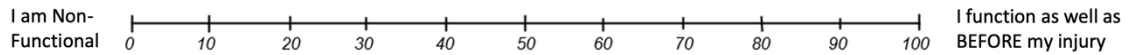
34. Personal care (such as taking a bath or shower, using the toilet or dressing and undressing)



35. Urinating (are you able to urinate; can you hold your urine)



36. Bowel movement (are you able to have a bowel movement; can you hold your bowel movement)



37. Sexual function



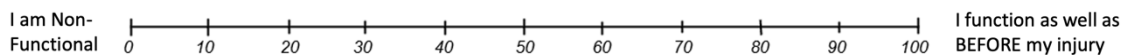
38. Emotional function (such as gloomy, worried or anxious feelings)



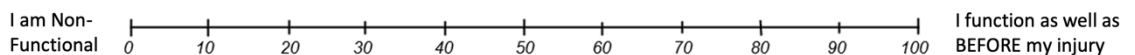
39. Energy level (such as fatigue or listlessness)



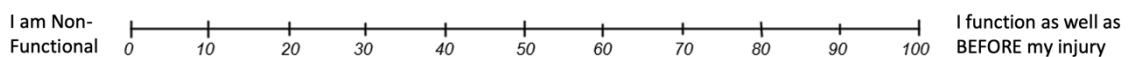
40. Sleep (such as number of hours and quality)



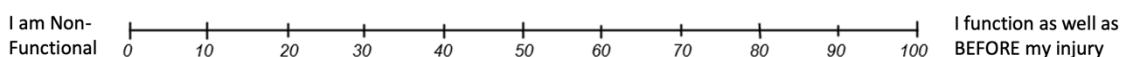
41. Stiffness of your neck and/or back (in terms of disability in overall performance)



42. Strength in your arms and/or legs (in terms of disability in overall performance)

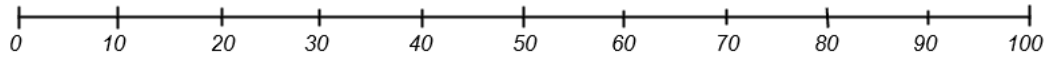


43. Back and / or neck pain (in terms of disability in overall performance)



Satisfaction:

44. With regards to your spinal fracture, please mark on the scale below how satisfied you were with your overall treatment. 0 being not satisfied at all and 100 being extremely satisfied.



Please give a brief description of why you chose your answer.

Demographics:

45. What is your height?

_____m or _____Ft_____In Don't know

46. What is your weight?

_____Kg or _____St_____lb Don't know

47. With regards to smoking please tick the correct box below

Never smoked Current smoker Ex-smoker

Years smoked for: Number of cigarettes per day:

Thank you for completing this questionnaire.

Contact details:

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