

**THE SCOLIOSIS RESEARCH SOCIETY INSTRUMENT FOR OUTCOME ASSESSMENT**  
**Spine Institute Patient Questionnaire**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

SS#: \_\_\_\_\_ Sex:  M  F

Pre-treatment 3 mos. 1 year \_\_\_\_years

The doctors are carefully evaluating the condition of your back before and after your treatment. Please choose the one best answer to each question. If you already have had treatment, please complete sections 1 and 2; otherwise, just complete section 1. Results will be kept strictly confidential.

**Section 1 - All patients complete this section. (Pre-treatment)**

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

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

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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 (ie 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

11. Do you feel that your condition affects your personal relationships with friends and family?

- Yes  No

12. Are your family experiencing financial difficulties because of your back?

- None  Some  Less

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

- None  Some  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 1 being very low and 9 being extremely high, how would you rate your self-image?

- (1) (2) (3) (4) (5) (6) (7) (8) (9)

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SS#: \_\_\_\_\_ Sex:  M  F

**Section 2: Post-treatment patients only.**

1. Has your back treatment changed your function and daily activities?  
 Increased  Not changed  Decreased

2. Has your back treatment changed your ability to enjoy sports/hobbies?  
 Increased  Not changed  Decreased

3. Has your back treatment \_\_\_\_\_ your back pain?  
 Increased  Not changed  Decreased

4. Has your treatment changed your confidence in personal relationships with others?  
 Increased  Not changed  Decreased

5. Has your treatment changed the way others view you?  
 Much Better  
 Better  
 Same  
 Worse  
 Much Worse

6. Has your treatment changed your self-image?  
 Increased  Not changed  Decreased

7. Are you satisfied with the results of your back treatment?  
 Extremely satisfied  
 Somewhat satisfied  
 Neither satisfied nor dissatisfied  
 Somewhat dissatisfied  
 Extremely dissatisfied

8. Compared to before your treatment, how do you feel you now look?  
 Much better  
 Better  
 Same  
 Worse  
 Much Worse

9. Would you have the same treatment again if you had the same condition?  
 Definitely yes  
 Probably yes  
 Not sure  
 Probably not  
 Definitely not