Johns Hopkins Spine Service
Patient Assessment
v2017.04.11

Cervical Pre-Operative Form

Spine problems have a big impact on your life. We are interested in knowing about the effects of your symptoms on your physical and emotional health.

Medical Record Number: ____________________

Date: ____________________ (MM/DD/YYYY)

First Name: ____________________

Last Name: ____________________

E-mail address: ____________________

When you provide your e-mail address you will be able to complete future surveys in the comfort of your own home rather than in the clinic.

Please select all statements that apply to you

- ❑1 I am seeking care for a back or leg problem.
- ❑2 I am seeking care for a neck or arm/shoulder problem.
- ❑3 I am seeking care for a spinal deformity such as scoliosis.

Does your neck or arm/shoulder problem cause you to have problems with balance that affects your walking; with manual dexterity (use of your hands); or bowel/bladder problems?

- ❑0 No
- ❑1 Yes

Please select the surgeon that you are seeing for your spine condition.

- ❑1 Dr. Ali Bydon
- ❑2 Dr. David Cohen
- ❑3 Dr. Ziya Gokaslan
- ❑4 Dr. Khaled Kebaish
- ❑5 Dr. Brian Neuman
- ❑6 Dr. Lee Riley
- ❑7 Dr. Daniel Sciubba
- ❑8 Dr. Timothy Witham
- ❑9 Dr. J.P. Wolinsky
- ❑10 Other/Not Listed

If you chose “Other/Not Listed” please enter the name of the surgeon that you are seeing for your spine problem. ____________________

Demographic and Clinical Characteristics

What is your date of birth?

_________________________ (MM/DD/YYYY)

What is your gender?
- ❑1 Male
- ❑2 Female

What is your current relationship status?
- ❑1 Single
- ❑2 Married
- ❑3 Widowed
- ❑4 Divorced
- ❑5 Separated
- ❑6 Living with partner

Are you currently working?
- ❑0 No
- ❑1 Yes

If you are not working please provide reason.
- ❑1 Retired (not due to illness)
- ❑2 Disabled and/or retired due to illness
- ❑3 Looking for work
- ❑4 Elected not to work (e.g. Homemaker)
- ❑5 Attending School

Do you currently use tobacco [cigarettes, cigars pipes or chewing tobacco]?
- ❑0 No
- ❑1 Yes

What is your current education level?
- ❑1 Less than 12th grade
- ❑2 12 grade diploma or GED
- ❑3 Some college no degree
- ❑4 Associate degree
- ❑5 College degree
- ❑6 Graduate degree

What is your ethnicity?
- ❑1 Hispanic or Latino
- ❑2 Not Hispanic or Latino
- ❑3 Don't know/Refused

What is your race? Please mark one or more.
- ❑1 American Indian/Native American
- ❑2 Asian
- ❑3 Black/African-American
- ❑4 Native Hawaiian/Pacific Islander
- ❑5 White
- ❑6 Don't know/Refused

Thinking about the total yearly income earned by you and your family members what would you say your total income was? Remember to include income received by you and any person residing in your house from a job social security or other retirement income.
- ❑1 Less than $5000
- ❑2 Between $5000 and $10000
- ❑3 Between $10000 and $30000
- ❑4 Between $30000 and $50000
- ❑5 Between $50000 and $80000
- ❑6 More than $80000
- ❑7 Don't know/Refused

In a typical week how many times do you engage in physical activity
- ❑1 None
- ❑2 1 time
- ❑3 2-3 times
- ❑4 More than 3 times

Treatment Expectations
After surgery how likely is it that you will experience the following?

	Not at all likely	Slightly likely	Somewhat likely	Very likely	Extremely likely
Relief from symptoms (pain or weakness)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Do more everyday household/yard activities	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Sleep more comfortably	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Go back to my usual job	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Go back to my usual recreational activities	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Prevent future disability	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4

How would you rate your expectation of having a successful surgery?

❑ 1 (Low) ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Medical History
Has a doctor or healthcare provider ever told you that you had the following? Please choose all that apply.

❑ 1 Myocardial infarct
❑ 2 Congestive heart failure
❑ 3 Peripheral vascular disease
❑ 4 Cerebrovascular disease (except hemiplegia)
❑ 5 Dementia
❑ 6 Chronic pulmonary disease
❑ 7 Arthritis or other connective tissue disease
❑ 8 Ulcer disease
❑ 9 Mild liver disease
❑ 10 Diabetes (without complications)
❑ 11 Diabetes with end organ damage
❑ 12 Hemiplegia
❑ 13 Moderate or severe renal disease
❑ 14 Solid tumor (non metastatic)
❑ 15 Leukemia
❑ 16 Lymphoma Multiple myeloma
❑ 17 Moderate or severe liver disease
❑ 18 Metastatic solid tumor
❑ 19 AIDS

Pain Intensity

Please rate your NECK pain by selecting the one number that best describes your pain at its WORST in the past week.

❑ _ (No Pain) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (Worst Pain)

Please rate your NECK pain by selecting the one number that best describes your pain at its AVERAGE in the past week.

❑ _ (No Pain) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (Worst Pain)

Please rate your ARM/SHOULDER pain by selecting the one number that best describes your pain at its WORST in the past week.

❑ _ (No Pain) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (Worst Pain)

Please rate your ARM/SHOULDER pain by selecting the one number that best describes your pain at its AVERAGE in the past week.

❑ _ (No Pain) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (Worst Pain)

Select the one number that describes how during the past week pain has interfered with your activities. Use the rating scale where "0" indicates that pain does not interfere and "10" indicates that pain completely interferes.

General activities	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Mood	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Walking ability	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Normal work (includes work outside the home and housework)	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Relations with other people	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Sleep	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
Enjoyment of life	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10

The next series of questions is designed to help us better understand how your **neck** pain affects your ability to manage everyday activities.

Please mark in each section the *one choice* that applies to you. Although you may consider that two of the statements in any one section relate to you please mark the choice that *most closely* describes your present-day situation.

Pain Intensity

❑$_0$ I have no pain at the moment.
❑$_1$ The pain is very mild at the moment.
❑$_2$ The pain is moderate at the moment.
❑$_3$ The pain is fairly severe at the moment.
❑$_4$ The pain is very severe at the moment.
❑$_5$ The pain is the worst imaginable at the moment.

Personal Care

❑$_0$ I can look after myself normally without causing extra pain.
❑$_1$ I can look after myself normally but it causes extra pain.
❑$_2$ It is painful to look after myself and I am slow and careful.
❑$_3$ I need some help but manage most of my personal care.
❑$_4$ I need help every day in most aspects of self -care.
❑$_5$ I do not get dressed. I wash with difficulty and stay in bed.

Lifting

❑$_0$ I can lift heavy weights without causing extra pain.
❑$_1$ I can lift heavy weights but it gives me extra pain.
❑$_2$ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned ie. on a table.
❑$_3$ Pain prevents me from lifting heavy weights but I can manage light weights if they are conveniently positioned.
❑$_4$ I can lift only very light weights.
❑$_5$ I cannot lift or carry anything at all.

Work

❑$_0$ I can do as much work as I want.
❑$_1$ I can only do my usual work; but no more.
❑$_2$ I can do most of my usual work; but no more.
❑$_3$ I can’t do my usual work.
❑$_4$ I can hardly do any work at all.
❑$_5$ I can’t do any work at all.

Headaches

❑$_0$ I have no headaches at all.
❑$_1$ I have slight headaches that come infrequently.
❑$_2$ I have moderate headaches that come infrequently.
❑$_3$ I have moderate headaches that come frequently.
❑$_4$ I have severe headaches that come frequently.
❑$_5$ I have headaches almost all the time.

Concentration

❑$_0$ I can concentrate fully without difficulty.
❑$_1$ I can concentrate fully with slight difficulty.
❑$_2$ I have a fair degree of difficulty concentrating.
❑$_3$ I have a lot of difficulty concentrating.
❑$_4$ I have a great deal of difficulty concentrating.
❑$_5$ I can’t concentrate at all.

Sleeping

- ❑$_0$ Pain does not prevent me from sleeping well.
- ❑$_1$ I can sleep well only by using tablets.
- ❑$_2$ Even when I take tablets I have less than 6 hours sleep.
- ❑$_3$ Even when I take tablets I have less than 4 hours sleep.
- ❑$_4$ Even when I take tablets I have less than 2 hours sleep.
- ❑$_5$ Pain prevents me from sleeping at all.

Driving

- ❑$_0$ I can drive my car without neck pain.
- ❑$_1$ I can drive as long as I want with slight neck pain.
- ❑$_2$ I can drive as long as I want with moderate neck pain.
- ❑$_3$ I can’t drive as long as I want because of moderate neck pain.
- ❑$_4$ I can hardly drive at all because of severe neck pain.
- ❑$_5$ I can’t drive my car at all because of neck pain.

Reading

- ❑$_0$ I can read as much as I want with no neck pain.
- ❑$_1$ I can read as much as I want with slight neck pain.
- ❑$_2$ I can read as much as I want with moderate neck pain.
- ❑$_3$ I can’t read as much as I want because of moderate neck pain.
- ❑$_4$ I can’t read as much as I want because of severe neck pain.
- ❑$_5$ I can’t read at all.

Recreation

- ❑$_0$ I have no neck pain during all recreational activities.
- ❑$_1$ I have some neck pain during all recreational activities.
- ❑$_2$ I have some neck pain with a few recreational activities.
- ❑$_3$ I have neck pain with most recreational activities.
- ❑$_4$ I can hardly do any recreational activities due to neck pain.
- ❑$_5$ I can’t do any recreational activities due to neck pain.

The next series of questions asks for your views about your health. For each of the following questions, please select an item that best describes your answer.

In general, would you say your health is

❑$_1$ Excellent
❑$_2$ Very good
❑$_3$ Good
❑$_4$ Fair
❑$_5$ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities and, if so, how much?

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	❑$_1$ No not limited at all	❑$_2$ Yes limited a little	❑$_3$ Yes limited a lot
Climbing several flights of stairs	❑$_1$ No not limited at all	❑$_2$ Yes limited a little	❑$_3$ Yes limited a lot

During the past four weeks, how much of the time have you had any of the following problems with your work or other daily activities as a result of your physical health?

Accomplished less than you would like	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time
Were limited in the kind of work or other activities	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time

During the past four weeks, how much of the time have you had any of the following problems with your work or other daily activities as a result of your emotional health (such as feeling depressed or anxious)?

Accomplished less than you would like	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time
Were limited in the kind of work or other activities	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time

How much did pain interfere with your normal work (including both work outside the home and housework)

❑$_1$ Not at all
❑$_2$ A little bit
❑$_3$ Moderately
❑$_4$ Quite a bit
❑$_5$ Extremely

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way that you have been feeling. How much of the time during the past for weeks …

Did you feel calm and peaceful?	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time
Did you have a lot of energy?	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time
Have you felt downhearted and depressed?	❑$_1$ All of the time	❑$_2$ Most of the time	❑$_3$ Some of the time	❑$_4$ A little of the time	❑$_5$ None of the time

How much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)

❑$_1$ All of the time
❑$_2$ Most of the time
❑$_3$ Some of the time
❑$_4$ A little of the time
❑$_5$ None of the time

With regard to your **neck** condition during the last week, please select the one response for each question that best applies. If your condition varies depending on the day or the time, select the one response that applies for your condition at its worst.

While in the sitting position, can you look up at the ceiling by tilting your head upward?

❑$_1$ Impossible
❑$_2$ Possible to some degree (with some effort)
❑$_3$ Possible without difficulty

Can you drink a glass of water without stopping despite your neck symptoms?

❑$_1$ Impossible
❑$_2$ Possible to some degree (with some effort)
❑$_3$ Possible without difficulty

While in the sitting position, can you turn your head toward the person who is seated to the side but behind you and speak to that person while looking at his or her face?

❑$_1$ Impossible
❑$_2$ Possible to some degree (with some effort)
❑$_3$ Possible without difficulty

Can you look at your feet when you go down the stairs?

❑$_1$ Impossible
❑$_2$ Possible to some degree (with some effort)
❑$_3$ Possible without difficulty

Can you fasten the front buttons of your blouse or shirt with both hands?

❑$_1$ Impossible
❑$_2$ Possible if I spend some time
❑$_3$ Possible without difficulty

Can you eat a meal with your dominant hand using a spoon or a fork?

❑$_1$ Impossible
❑$_2$ Possible if I spend some time
❑$_3$ Possible without difficulty

Can you raise your arm? (Answer for the weaker side)

❑$_1$ Impossible
❑$_2$ Possible up to shoulder level
❑$_3$ Possible, though the elbow and/or wrist is a little flexed
❑$_4$ I can raise it straight upward

Can you walk on a flat surface

❑$_1$ Impossible
❑$_2$ Possible but slowly even with support
❑$_3$ Possible only with support of a handrail, cane, or walker
❑$_4$ Possible but slowly without any support
❑$_5$ Possible without difficulty

Can you stand on either leg without the support of your hand? (The need to support yourself)

❑$_1$ Impossible with either leg
❑$_2$ Possible on either leg for more than ten seconds
❑$_3$ Possible on both legs individually for more than ten seconds

Do you have difficulty going up the stairs?

❑$_1$ I have great difficulty
❑$_2$ I have some difficulty
❑$_3$ I have no difficulty

Do you have difficulty in one of the following motions: bending forward, kneeling, or stooping?

❑$_1$ I have great difficulty
❑$_2$ I have some difficulty
❑$_3$ I have no difficulty

Do you have difficulty in walking for more than 15 minutes

❑$_1$ I have great difficulty
❑$_2$ I have some difficulty
❑$_3$ I have no difficulty

Question	Response options
Do you have urinary incontinence?	❑1 Always ❑2 Frequently ❑3 When retaining urine over a period of more than 2 hours ❑4 When sneezing or straining ❑5 No
How often do you go to the bathroom at night?	❑1 Three or more times ❑2 Once or twice ❑3 Rarely
Do you have a feeling of residual urine in your bladder after voiding?	❑1 Most of the time ❑2 Some of the time ❑3 Rarely
Can you initiate (start) your urine stream immediately when you want to void?	❑1 Usually not ❑2 Sometimes ❑3 Most of the time
How is your present health?	❑1 Poor ❑2 Fair ❑3 Good ❑4 Very Good ❑5 Excellent
Have you been unable to do your work or ordinary activities as well as you would like?	❑1 I have been unable to do them at all ❑2 I have been unable to do them most of the time ❑3 I have sometimes been unable to do them ❑4 I have been able to do them most of the time ❑5 I have always been able to do them
Has your work routine been hindered because of the pain?	❑1 Greatly ❑2 Moderately ❑3 Slightly (somewhat) ❑4 Little (minimally) ❑5 Not at all
Have you been discouraged or depressed?	❑1 Always ❑2 Frequently ❑3 Sometimes ❑4 Rarely ❑5 Never
Do you feel exhausted?	❑1 Always ❑2 Frequently ❑3 Sometimes ❑4 Rarely ❑5 Never
Have you felt happy?	❑1 Always ❑2 Frequently ❑3 Sometimes ❑4 Rarely ❑5 Never

Do you think that you are in decent health?

- ❑1 Not at all (my health is very poor)
- ❑2 Barely (my health is poor)
- ❑3 Not very much (my health is average)
- ❑4 Fairly (my health is better than average)
- ❑5 Yes (I am healthy)

Do you feel that your health will get worse?

- ❑1 Very much so
- ❑2 A little bit at a time
- ❑3 Sometimes yes and sometimes no
- ❑4 Not very much
- ❑5 Not at all

Regarding 0 as "no pain (numbness) at all" and 10 as "the most intense pain (numbness) imaginable", choose a number between 0 and 10 to show the degree of pain (numbness) when your symptom is at its worst during the last week.

If you feel pain or stiffness in your neck or shoulders, mark the degree	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
If you feel tightness in your chest, mark the degree	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
If you feel pain or numbness in your arms or hands, mark the degree	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
If you feel pain or numbness from chest to toe, mark the degree	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10

The next series of statements ask for your views about your swallowing ability. ***If you do not have a swallowing problem, proceed to Page 13.***

The following statements have been made by people who have problems with their swallowing. Some of the statements may apply to you. Please read each statement and select the response that best reflects your experience in the past week.

Statement					
My swallowing limits my day-to-day activities.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I am embarrassed by my eating habits.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
People have difficulty cooking for me.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
Swallowing is more difficult at the end of the day.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I do not feel self-conscious when I eat.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I am upset by my swallowing problem.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
Swallowing takes great effort.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I do not go out because of my swallowing problem.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
It takes me longer to eat because of my swallowing problem.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
People ask me, “Why can’t you eat that?”	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
Other people are irritated by my eating problem.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I cough when I try to drink liquid.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
My swallowing problems limit my social and personal life.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I feel free to go out to eat with my friends, neighbors, and relatives.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I limit my food intake because of my swallowing difficulty.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I cannot maintain my weight because of my swallowing difficulty.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree

I have low self esteem because of my swallowing problems.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I feel that I am swallowing a huge amount of food.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree
I feel excluded because of my eating habits.	❑1 Strongly agree	❑2 Agree	❑3 No opinion	❑4 Disagree	❑5 Strongly disagree

Below are some statements that people make when talking about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally. Your answers should be true to you and not what you think your doctor wants to hear.

Statement				
When all is said and done, I am the person responsible for my health condition(s)	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
Taking an active role in my own health is the most important factor in determining my health and ability to function.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition(s).	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I know what each of my prescribed medications do.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can tell when I need to go get medical care and when I can handle a health problem on my own.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can tell a doctor concerns I have even when he or she does not ask.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can follow through on medical treatments that I need to do at home.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I understand the nature and causes of my health condition(s).	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I know the different medical treatment options available for my health condition(s).	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I have been able to maintain the lifestyle changes for my health condition(s) that I have made.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I know how to prevent further problems with my health condition(s).	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can figure out solutions when new situations or problems arise with my health condition(s).	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree
I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.	❑ 1 Strongly agree	❑ 2 Agree	❑ 3 Disagree	❑ 4 Strongly disagree

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

Feeling nervous, anxious, or on edge	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Not being able to sleep or control worrying	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Worrying too much about different things	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Trouble relaxing	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Being so restless that it is hard to sit still	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Becoming easily annoyed or irritated	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day
Feeling afraid, as if something awful might happen	❑$_1$ Not at all	❑$_2$ Several days	❑$_3$ Over half the days	❑$_4$ Nearly every day

If you checked off any problems in the table above, how difficult have these problems made it for you to do you work, take care of things, or get along with other people?

❑$_1$ Not difficult at all
❑$_2$ Somewhat difficult
❑$_3$ Very difficult
❑$_4$ Extremely difficult

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

Little interest or pleasure in doing things	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Feeling down, depressed, or hopeless	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Trouble falling or staying asleep, or sleeping too much	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Feeling tired or having little energy	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Poor appetite or overeating	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day
Moving or speaking so slowly that other people could have notices? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑$_{1}$ Not at all	❑$_{2}$ Several days	❑$_{3}$ Over half the days	❑$_{4}$ Nearly every day

If you checked off any problems in the table above, how difficult have these problems made it for you to do you work, take care of things, or get along with other people?

- ❑$_{1}$ Not difficult at all
- ❑$_{2}$ Somewhat difficult
- ❑$_{3}$ Very difficult
- ❑$_{4}$ Extremely difficult

Pain interference
In the past 7 days …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your enjoyment of life?	❑1	❑2	❑3	❑4	❑5
How much did pain interfere with your ability to concentrate?	❑1	❑2	❑3	❑4	❑5
How much did pain interfere with your day to day activities?	❑1	❑2	❑3	❑4	❑5
How much did pain interfere with your enjoyment of recreational activities?	❑1	❑2	❑3	❑4	❑5
How much did pain interfere with doing your tasks away from home (e.g. getting groceries, running errands)?	❑1	❑2	❑3	❑4	❑5

In the past 7 days …	Never	Rarely	Sometimes	Often	Always
How often did pain keep you from socializing with others?	❑1	❑2	❑3	❑4	❑5

Physical function
In the past 7 days …

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	❑1	❑2	❑3	❑4	❑5
Does you health now limit you in walking more than a mile?	❑1	❑2	❑3	❑4	❑5
Does your health now limit you in climbing one flight of stairs?	❑1	❑2	❑3	❑4	❑5
Does your health now limit you in lifting or carrying groceries?	❑1	❑2	❑3	❑4	❑5
Does your health now limit you in bending, kneeling, or stooping?	❑1	❑2	❑3	❑4	❑5

Physical function
In the past 7 days …

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	❑1	❑2	❑3	❑4	❑5
Are you able to dress yourself, including tying shoelaces and doing buttons?	❑1	❑2	❑3	❑4	❑5
Are you able to shampoo your hair?	❑1	❑2	❑3	❑4	❑5
Are you able to wash and dry your body?	❑1	❑2	❑3	❑4	❑5
Are you able to get on and off the toilet?	❑1	❑2	❑3	❑4	❑5

Emotional Distress - Anxiety
In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
I felt fearful	❑1	❑2	❑3	❑4	❑5
I felt anxious	❑1	❑2	❑3	❑4	❑5
I felt worried	❑1	❑2	❑3	❑4	❑5
I found it hard to focus on anything other than my anxiety	❑1	❑2	❑3	❑4	❑5
I felt nervous	❑1	❑2	❑3	❑4	❑5
I felt uneasy	❑1	❑2	❑3	❑4	❑5
I felt tense	❑1	❑2	❑3	❑4	❑5

Emotional Distress - Depression
In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
I felt worthless	❑1	❑2	❑3	❑4	❑5
I felt that I had nothing to look forward to	❑1	❑2	❑3	❑4	❑5
I felt helpless	❑1	❑2	❑3	❑4	❑5
I felt sad	❑1	❑2	❑3	❑4	❑5
I felt like a failure	❑1	❑2	❑3	❑4	❑5
I felt depressed	❑1	❑2	❑3	❑4	❑5
I felt unhappy	❑1	❑2	❑3	❑4	❑5
I felt hopeless	❑1	❑2	❑3	❑4	❑5

Fatigue
In the past 7 days …

	Never	Rarely	Sometimes	Often	Always
How often did you feel tired?	❑1	❑2	❑3	❑4	❑5
How often did you experience extreme exhaustion?	❑1	❑2	❑3	❑4	❑5
How often did you run out of energy?	❑1	❑2	❑3	❑4	❑5
How often did fatigue limit you at work (include work at home)?	❑1	❑2	❑3	❑4	❑5
How often were you too tired to think clearly	❑1	❑2	❑3	❑4	❑5
How often were you too tired to take a bath or shower?	❑1	❑2	❑3	❑4	❑5
How often did you have enough energy to exercise strenuously?	❑1	❑2	❑3	❑4	❑5

Sleep Disturbance
In the past 7 days …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless	❑1	❑2	❑3	❑4	❑5
I was satisfied with my sleep	❑1	❑2	❑3	❑4	❑5
My sleep was refreshing	❑1	❑2	❑3	❑4	❑5
I had difficulty falling asleep	❑1	❑2	❑3	❑4	❑5

In the past 7 days ….

	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep	❑1	❑2	❑3	❑4	❑5
I had trouble sleeping	❑1	❑2	❑3	❑4	❑5
I got enough sleep	❑1	❑2	❑3	❑4	❑5

In the past 7 days ….

	Very poor	Poor	Fair	Good	Very good
My sleep quality was	❑1	❑2	❑3	❑4	❑5

Satisfaction with participation in social roles
In the past 7 days …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am satisfied with my ability to do things for my family	❑1	❑2	❑3	❑4	❑5
I am satisfied with my ability to meet the needs of those who depend on me	❑1	❑2	❑3	❑4	❑5
I am satisfied with my ability to perform my daily routines	❑1	❑2	❑3	❑4	❑5
I am satisfied with my ability to run errands	❑1	❑2	❑3	❑4	❑5
I am satisfied with my ability to work (include work at home)	❑1	❑2	❑3	❑4	❑5
I am satisfied with my ability to do household chores/tasks	❑1	❑2	❑3	❑4	❑5
I am satisfied with how much work I can do (include work at home)	❑1	❑2	❑3	❑4	❑5