Johns Hopkins Spine Service
Patient Assessment
v2017.04.11

# Lumbar/Deformity Follow-up 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)

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 the one item that most accurately reflects your satisfaction with surgery.
- ❑1 The treatment met my expectations
- ❑2 I did not improve as much as I had hoped but would undergo the same treatment for the same outcome
- ❑3 I did not improve as much as I had hoped and I would not undergo the same treatment for the same outcome
- ❑4 I am the same or worse than before surgery

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

If you are <u>not currently working</u>, 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

Since your surgery or last visit, have you received any physical therapy?
- ❑0 No
- ❑1 Yes

If yes, how many clinic sessions have you had? _____
(clinic sessions)

If yes, how many home sessions have you had? _____
(home sessions)

Since your surgery or last visit, have you been admitted to the hospital?
- ❑0 No
- ❑1 Yes

If yes, please describe your most recent hospitalization: _____

Since your surgery or last visit, have you had additional spine surgery?
- ❑0 No
- ❑1 Yes

If yes, please describe your recent spine surgery:

Since your surgery or last visit, have you been admitted to the hospital?
❑0 No
❑1 Yes

Are you currently taking narcotic medications?
❑0 No
❑1 Yes

**Pain Intensity**

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

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

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

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

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

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

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

❑0 (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 **back** 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 can tolerate the pain without having to use painkillers.
- ❑1 The pain is bad but I can manage without painkillers.
- ❑2 Painkillers give me complete relief from pain.
- ❑3 Painkillers give me moderate relief from pain.
- ❑4 Painkillers give me very little relief from pain.
- ❑5 Painkillers have no effect on the pain and I do not use them.

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 (i.e. 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.

Walking

- ❑0 Pain does not prevent me from walking any distance.
- ❑1 Pain prevents me from walking more than 1 mile.
- ❑2 Pain prevents me from walking more than 0.5 miles.
- ❑3 Pain prevents me from walking more than 0.25 miles.
- ❑4 I can only walk using a stick or crutches.
- ❑5 I am in bed most of the time and have to crawl to the toilet.

Sitting

- ❑0 I can sit in any chair as long as I like.
- ❑1 I can only sit in my favorite chair as long as I like.
- ❑2 Pain prevents me from sitting more than 1 hour.
- ❑3 Pain prevents me from sitting more than 0.5 hours.
- ❑4 Pain prevents me from sitting more than 10 minutes.
- ❑5 Pain prevents me from sitting at all.

Standing

- ❑0 I can stand as long as I like without any extra pain.
- ❑1 I can stand as long as I like but it gives me extra pain.
- ❑2 Pain prevents me from standing more than 1 hour.
- ❑3 Pain prevents me from standing more than 30 minutes.
- ❑4 Pain prevents me from standing more than 10 minutes.
- ❑5 Pain prevents me from standing 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.

Sex Life

- ❑0 My sex life is normal and causes no extra pain.
- ❑1 My sex life is normal but causes some extra pain.
- ❑2 My sex life is nearly normal but is very painful.
- ❑3 My sex life is severely restricted by pain.
- ❑4 My sex life is nearly absent because of pain.
- ❑5 Pain prevents any sex life at all.

Social Life

- ❑0 My social life is normal and gives me no extra pain.
- ❑1 My social life is normal but increases the degree of pain.
- ❑2 Pain has no significant effect on my social life apart from limiting energetic interests such as dancing.
- ❑3 Pain has restricted my social life and I do not go out as often.
- ❑4 Pain has restricted my social life to my home.
- ❑5 I have no social life because of pain.

Traveling

- ❑0 I can travel anywhere without extra pain.
- ❑1 I can travel anywhere but it gives me extra pain.
- ❑2 Pain is bad but I manage journeys over 2 hours.
- ❑3 Pain restricts me to journeys of less than 1 hour.
- ❑4 Pain restricts me to short necessary journeys under 30 minutes.
- ❑5 Pain prevents me from traveling except to the doctor or hospital.

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<br>❑2 Very good<br>❑3 Good<br>❑4 Fair<br>❑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 <u>physical health</u>?

| | | | | | |
|---|---|---|---|---|---|
| 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 <u>emotional health</u> (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<br>❑2 A little bit<br>❑3 Moderately | ❑4 Quite a bit<br>❑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<br>❑2 Most of the time<br>❑3 Some of the time | ❑4 A little of the time<br>❑5 None of the time |

We are carefully evaluating the condition of your back and it is important that you answer each of these questions yourself. Please select the one best answer to each question.

Which one of the following best describes the amount of pain you have experienced during the past six months?

- ❑1 None
- ❑2 Mild
- ❑3 Moderate
- ❑4 Moderate to severe
- ❑5 Severe

Which one of the following best describes the amount of pain you have experienced over the last month?

- ❑1 None
- ❑2 Mild
- ❑3 Moderate
- ❑4 Moderate to severe
- ❑5 Severe

During the past 6 months, have you been a very nervous person?

- ❑1 None of the time
- ❑2 A little of the time
- ❑3 Some of the time
- ❑4 Most of the time
- ❑5 All of the time

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

- ❑1 Very happy
- ❑2 Somewhat happy
- ❑3 Neither happy nor unhappy
- ❑4 Somewhat unhappy
- ❑5 Very unhappy

What is your current level of activity?

- ❑1 Bedridden
- ❑2 Primarily no activity
- ❑3 Light labor and light sports
- ❑4 Moderate labor and moderate sports
- ❑5 Fully activities without restrictions

How do you look in clothes?

- ❑1 Very good
- ❑2 Good
- ❑3 Fair
- ❑4 Bad
- ❑5 Very bad

In the past 6 months, have you felt so down in the dumps that nothing could cheer you up?

- ❑1 Very often
- ❑2 Often
- ❑3 Sometimes
- ❑4 Rarely
- ❑5 Never

Do you experience back pain when at rest?

- ❑1 Very often
- ❑2 Often
- ❑3 Sometimes
- ❑4 Rarely
- ❑5 Never

What is your current level of work/school activity?

- ❑1 100% normal
- ❑2 75% normal
- ❑3 50% normal
- ❑4 25% normal
- ❑5 0% normal

Which of the following best describes the appearance of your trunk: defined as the human body except for the head and extremities?

- ❑1 Very good
- ❑2 Good
- ❑3 Fair
- ❑4 Bad
- ❑5 Very bad

Which one of the following best describes your pain medication use for back pain?

- ❑1 None
- ❑2 Non-narcotics weekly or less
- ❑3 Non narcotics daily
- ❑4 Narcotics weekly or less
- ❑5 Narcotics daily

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

- ❑1 Never
- ❑2 Rarely
- ❑3 Sometimes
- ❑4 Often
- ❑5 Very often

Have you felt calm and peaceful during the past 6 months?

- ❑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

Do you feel that your back condition affects your personal relationships?

- ❑1 None
- ❑2 Slightly
- ❑3 Mildly
- ❑4 Moderately
- ❑5 Severely

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

- ❑1 None
- ❑2 Slightly
- ❑3 Mildly
- ❑4 Moderately
- ❑5 Severely

In the past 6 months, have you felt down hearted and blue?

- ❑1 Never
- ❑2 Rarely
- ❑3 Sometimes
- ❑4 Often
- ❑5 Very often

In the last 3 months, have you taken any days off of work, including household work or school, because of back pain?

- ❑1 0 days
- ❑2 1 day
- ❑3 2 days
- ❑4 3 days
- ❑5 4 or more days

Does your back condition limit your going out with friends/family?

- ❑1 Never
- ❑2 Rarely
- ❑3 Sometimes
- ❑4 Often
- ❑5 Very often

Do you feel attractive with your current back condition?

- ❑1 Yes very
- ❑2 Yes somewhat
- ❑3 Neither attractive nor unattractive
- ❑4 No not very much
- ❑5 No not at all

Have you been a happy person during the past 6 months?

- ❑1 None of the time
- ❑2 A little of the time
- ❑3 Some of the time
- ❑4 Most of the time
- ❑5 All of the time

Are you satisfied with the results of your back management?

- ❑1 Very satisfied
- ❑2 Satisfied
- ❑3 Neither satisfied nor unsatisfied
- ❑4 Unsatisfied
- ❑5 Very unsatisfied

Would you have the same management again if you had the same condition?

- ❑1 Definitely yes
- ❑2 Probably yes
- ❑3 Not sure
- ❑4 Probably not
- ❑5 Definitely not

We are testing a shorter version of the 22 item scale that you just completed.

Please answer each of these questions yourself. Please select the one best answer to each question. Your responses may help us shorten our overall assessment of patients with conditions like yours.

Which one of the following best describes the amount of pain you have experienced during the past six months?

- ❑1 None
- ❑2 Mild
- ❑3 Moderate
- ❑4 Severe

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

- ❑1 Unhappy
- ❑2 Somewhat unhappy
- ❑3 Somewhat happy
- ❑4 Happy

How do you look in clothes?

- ❑1 Bad
- ❑2 Somewhat bad
- ❑3 Somewhat good
- ❑4 Good

Which of the following best describes the appearance of your trunk: defined as the human body except for the head and extremities?

- ❑1 Very poor
- ❑2 Poor
- ❑3 Fair
- ❑4 Good
- ❑5 Very good

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

- ❑1 Never
- ❑2 Rarely
- ❑3 Sometimes
- ❑4 Often
- ❑5 Very Often

Do you feel attractive with your current back condition?

- ❑1 No not at all
- ❑2 No not very much
- ❑3 Yes somewhat
- ❑4 Yes very

Have you been a happy person during the past 6 months?

- ❑1 None of the time
- ❑2 A little of the time
- ❑3 Most of the time
- ❑4 All of the time

The next series of statements ask for your views about your swallowing ability. ***If you do not have a swallowing problem, proceed to Page 12.***

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.

| | | | | | |
|---|---|---|---|---|---|
| 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.

| | | | | |
|---|---|---|---|---|
| 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 |