SRS-30 Patient Questionnaire

Modified 11/12/03

Version 30 (Encompasses Versions 22 and 24)

Patient Name:_____ **Age:**_____ **Date:**_____

Medical Record #_____ **SS:**_____

Exam: Pre-treatment 3 mos. 6 mos. 1 year _____ years

Your doctors are carefully evaluating the condition of your back before and after your treatment. Please circle the one best answer to each question unless otherwise indicated. If you already have had surgery, please complete sections 1 and 2. Otherwise, just complete section 1.

All results will be kept confidential.

Section 1: All patients

1. **Which one of the following best describes the amount of pain you have experienced during the past 6 months?**
   - ☐ None
   - ☐ Mild
   - ☐ Moderate
   - ☐ Moderate to severe
   - ☐ Severe

2. **Which one of the following best describes the amount of pain you have experienced over the last month?**
   - ☐ None
   - ☐ Mild
   - ☐ Moderate
   - ☐ Moderate to severe
   - ☐ Severe

3. **During the past 6 months have you been a very nervous person?**
   - ☐ None of the time
   - ☐ A little of the time
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time

4. **If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?**
   - ☐ Very happy
   - ☐ Somewhat happy
   - ☐ Neither happy nor unhappy
   - ☐ Somewhat unhappy
   - ☐ Very unhappy

5. **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

6. **How do you look in clothes?**
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Bad
   - ☐ Very bad

7. **In the past 6 months have you felt so down in the dumps that nothing could cheer you up?**
   - ☐ Very often
   - ☐ Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

8. **Do you experience back pain when at rest?**
   - ☐ Very often
   - ☐ Often
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

9. **What is your current level of work/school activity?**
   - ☐ 100% normal
   - ☐ 75% normal
   - ☐ 50% normal
   - ☐ 25% normal
   - ☐ 0% normal

10. **Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?**
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐ Very poor

11. **Which one of the following best describes your medication usage for your back?**
    - ☐ None
    - ☐ Non-narcotics weekly or less (e.g., Tylenol, Ibuprofen)
    - ☐ Non-narcotics daily
    - ☐ Narcotics weekly or less (e.g., Percocet, Lorcet, Codeine, Darvocet)
    - ☐ Narcotics daily
    - ☐ Other (please specify below)

    Medication:

    _____

    Usage (weekly or less or daily):

    _____

12. **Does your back limit your ability to do things around the house?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

13. **Have you felt calm and peaceful during the past 6 months?**
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

14. **Do you feel that your back condition affects your personal relationships?**
- ☐ None
- ☐ Slightly
- ☐ Mildly
- ☐ Moderately
- ☐ Severely

15. **Are you and/or your family experiencing financial difficulties because of your back?**
- ☐ Severely
- ☐ Moderately
- ☐ Mildly
- ☐ Slightly
- ☐ None

16. **In the past 6 months have you felt down-hearted and blue?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

17. **In the last 3 months have you taken any sick days from work/school due to back pain and, if so, how many?**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

18. **Do you go out more or less than your friends?**
- ☐ Much more
- ☐ More
- ☐ Same
- ☐ Less
- ☐ Much less

19. **Do you feel attractive with your current back condition?**
- ☐ Yes, very
- ☐ Yes, somewhat
- ☐ Neither attractive nor unattractive
- ☐ No, not very much
- ☐ No, not at all

20. **Have you been a happy person during the past 6 months?**
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

21. **Are you satisfied with the results of your back management?**
- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither satisfied nor unsatisfied
- ☐ Unsatisfied
- ☐ Very unsatisfied

22. **Would you have the same management again if you had the same condition?**
- ☐ Definitely yes
- ☐ Probably yes
- ☐ Not sure
- ☐ Probably not
- ☐ Definitely not

23. **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

Section 2: Post-surgery patients only

24. **Compared with before treatment, how do you feel you now look?**
- ☐ Much better
- ☐ Better
- ☐ Same
- ☐ Worse
- ☐ Much worse

25. **Has your back treatment changed your function and daily activity?**
☐ Increased ☐ Not changed ☐ Decreased

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

27. **Has your back treatment _____ your back pain?**
☐ Increased ☐ Not changed ☐ Decreased

28. **Has your treatment changed your confidence in personal relationships with others?**
☐ Increased ☐ Not changed ☐ Decreased

29. **Has your treatment changed the way others view you?**
- ☐ Much better
- ☐ Better
- ☐ Same
- ☐ Worse
- ☐ Much worse

30. **Has your treatment changed your self-image?**
☐ Increased ☐ Not changed ☐ Decreased

SRS-30 Patient Questionnaire/Score Sheet

Name: _____ Today's Date: _____ (Mo Day Year)

Age: _____ (Yr) _____ (Mo) Sex: M F

Diagnoses: _____

_____

_____

Deformity/Size _____ _____

Management: (Circle one) **I**nitial Evaluation
Observation
Pre Brace
Brace _____ (Type)
Other _____ (Describe)

Pre Surgery Indication _____

Surgery	Arthrodesis UV	Arthrodesis LV	Instrumentation UV	Instrumentation LV
Post	___	___	___	___
Ant	___	___	___	___

Date Initiated: ____ ____ ____ (Mo Day Yr)

Follow-up _____ (Yrs) _____ (Mo)

DOMAIN	(Score: 5 Best – 1 Worst)	Post Surgery Questions	Score Pt/Possible(Max) A	#Questions Answered(Possible) B	Mean Score *** A÷B
Function/ Activity	___ ___ ___ ___ ___ (5* 9 12 15 18)	___ ___ (25 26)	____(___)(25) (35)+	____(5) (7)+	____
Pain	___ ___ ___ ___ ___ (1 2 8 11 17)	___ (27)	____(___)(25) (30)	____(5) (6)	____
Self Image/ appearance	___ ___ ___ ___ ___ ___ (4 6 10 14 19 23)	___ ___ ___ (28 29 30)	____(___)(30) (45)	____(6) (9)	____
Mental health**	___ ___ ___ ___ ___ (3 7 13 16 20)		____(___)(25)	____(5)	____
SUB TOTAL			____(___)(105) (135)	____(21) (27)	____
Satisfaction with management	___ ___ (21 22)	___ (24)	____(___)(10) (15)	____(2) (3)	____
TOTAL			____(___)(115) (150) +max/possible with post surgery questions	____(23) (30)	____ ***Mean Score 5 Best 1 Worst

*Question Number
**Questions adopted with permission from SF-36

SCORING INSTRUCTIONS
Unanswered questions – reduce questions answered denominator by appropriate number
Delete questions with more than one response
Domain can't be scored if fewer than 3 questions answered