To be completed by the PATIENT

1. What is your level of activity?
   - Full activities without restriction
   - Moderate activities out of house
   - Mobility limited to within house
   - Bed to chair activity
   - Bedridden

2. What is your ability to work (including at home)/study?
   - Unlimited
   - 4-8 hours per day
   - 2-4 hours per day
   - Less than 2 hours per day
   - Not at all

3. Does your spine limit your ability to care for yourself?
   - Not at all
   - A little bit
   - Somewhat
   - Quite a bit
   - Very much

4. Do you require assistance from others to travel outside the home?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very often

5. What assistance do you need with your walking?
   - None
   - A cane
   - A walker/2 canes
   - Assistance from others
   - Cannot walk at all

6. Do you leave the house for social functions?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very often

7. Do you have weakness in your legs?
   - None
   - Mild occasionally
   - Mild constantly
   - Moderate constantly
   - Severe constantly

8. Do you have weakness in your arms?
   - None
   - Mild occasionally
   - Mild constantly
   - Moderate constantly
   - Severe constantly

9. Do you have difficulty controlling your bowel function beyond episodes of diarrhea/constipation?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very often

10. Do you have difficulty controlling your bladder function?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Requires catheterization

11. Overall, on average, how much back/neck pain do you have?
    - None
    - Very mild
    - Mild
    - Moderate
    - Severe

12. When you are in your most comfortable position, do you still experience back/neck pain (limiting your sleep)?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Very often
13. How much has your pain limited your mobility (sitting, standing, walking)?
- Never
- Rarely
- Sometimes
- Often
- Constantly

14. How confident do you feel in your ability to manage your pain on your own?
- Not confident at all
- Minimally confident
- Moderately confident
- Mostly confident
- Completely confident

15. When I feel pain, it is awful and I feel that it overwhelms me.
- Never
- Rarely
- Sometimes
- Often
- Very often

16. Have you felt depressed?
- Never
- Rarely
- Sometimes
- Often
- Very often

17. Do you feel anxiety about your health related to your spine?
- Never
- Rarely
- Sometimes
- Often
- Very often

18. Does your spine influence your ability to concentrate on conversations, reading, and television?
- Never
- Rarely
- Sometimes
- Often
- Very often

19. Do you feel that your spine condition affects your personal relationships?
- Never
- Rarely
- Sometimes
- Often
- Very often

20. Are you comfortable meeting new people?
- Never
- Rarely
- Sometimes
- Often
- Very often

Complete only AFTER your treatment

21. Are you satisfied with the results of your spine tumor management?
- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied

22. Would you choose the same management of your spine tumor again?
- Definitely yes
- Probably yes
- Not sure
- Probably not
- Definitely not

23. How has treatment of your spine changed your physical function and ability to pursue activities of daily living?
- Much better
- Somewhat better
- No change
- Somewhat worse
- Much worse

24. How has treatment of your spine affected your spinal cord and/or nerve function?
- Much better
- Somewhat better
- No change
- Somewhat worse
- Much worse

25. How has your treatment affected your overall pain from your spine?
- Much better
- Somewhat better
- No change
- Somewhat worse
- Much worse

26. How has treatment of your spine changed your depression and anxiety?
- Much better
- Somewhat better
- No change
- Somewhat worse
- Much worse

27. How has treatment of your spine changed your ability to function socially?
- Much better
- Somewhat better
- No change
- Somewhat worse
- Much worse

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