### Spine Oncology Study Group Outcomes Questionnaire 2.0 (SOSGOQ2.0)

**Directions:** This set of questions asks for how you view your health status. Please think about your level of functioning and symptoms over the past 4 weeks while filling out this questionnaire. It is important that you answer each of the questions **YOURSELF.** Mark ONLY ONE ANSWER for each question. Questions 21-27 should only be completed **AFTER** your treatment, at follow-up visits.

| Patient Name: ____________________________ |
| Date (MM/DD/YY): _____ / _____ / _____ |
| Patient ID: ____________________________  |

(to be filled in by the health professional)

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### 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

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**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