### SRS-30 Patient Questionnaire Scoliosis

**Directions**
- Use a #2 soft pencil for marking.
- Text answers must be entered with the web interface.
- All questions must be answered unless otherwise indicated.
- Completely fill in boxes to record answers.

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

### Examination Date

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### Interval with reference to surgery / treatment

- < 6 months
- 6 months - 1 year
- 1 year - 2 years
- 2 years - 5 years
- 5 years - 8 years
- 8 years - 11 years
- 11 years - 14 years
- 14 years - 17 years
- 17 years - 20 years
- 20 years - 23 years
- 23 years - 26 years
- > 26 years

### Section 1

**01. 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

**02. 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

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

**04. 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 unhappy
- Somewhat unhappy
- Neither happy nor unhappy
- Somewhat happy
- Very happy

**05. 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

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

**07. 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

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

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

**10. Which one 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

**11a. Which one of the following best describes your medication usage for your back?** (Mark one only)
- None
- Non-narcotics weekly or less (e.g. Aspirin, Tylenol, Ibuprofen)
- Non-narcotics daily
- Narcotics weekly or less (e.g. Tylenol III, Lorocet, Percocet)
- Narcotics daily
- Other

**11b. If ‘Other’ medication, please specify.................................**

**11c. If ‘Other’ medication, describe your usage**
- Daily
- Weekly or less

**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 condition affects your personal relationships?**
- None
- Slightly
- Mildly
- Moderately
- Severely
15. Are you and/or your family experiencing financial difficulties because of your back?
   - Severe
   - Moderate
   - Mild
   - Slight
   - None

16. In the past 6 months have you felt downhearted 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?
   - No, not at all
   - No, not very much
   - Neither attractive nor unattractive
   - Yes, somewhat
   - Yes, very

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 unsatisfied
   - Unsatisfied
   - Neither satisfied nor unsatisfied
   - Satisfied
   - Very satisfied

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

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 ability to enjoy 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

Please comment if you wish/ Initials :

All results will be kept confidential

Please mark on the drawings any areas where you feel pain. If you are not having any pain, leave blank and initial. Use the following key to show particular types of pain:

KEY: Pins& needles = 00000 Stabbing = //////
      Burning = XXXXX Deep ache = ZZZZZZ

Information not read by scanner.
Please fill out the SRS-30 pain assessment to collect data.

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