

SPINAL STENOSIS TREATMENT OUTCOME QUESTIONNAIRE

Patient Name _____

Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your pain has affected your SYMPTOM SEVERITY, PHYSICAL FUNCTION and SURGERY SATISFACTION. Please mark the one item which most closely describes your problem right now.

SYMPTOM SEVERITY SCALE

In the LAST MONTH, how would you describe:

1. The pain you have had on average including pain in your back, buttocks and pain that goes down the legs?	None	Mild	Moderate	Severe	Very Severe
2. How often have you had back, buttock or leg pain?	< Once a week	At least once a week.	Every day for at least a few minutes	Every day, for most of the day.	Every day, every minute
3. The pain in your back or buttocks?	None	Mild	Moderate	Severe	Very Severe
4. The pain in your legs or feet?	None	Mild	Moderate	Severe	Very Severe
5. Numbness or tingling in your legs or feet?	None	Mild	Moderate	Severe	Very Severe
6. Weakness in your legs or feet?	None	Mild	Moderate	Severe	Very Severe
7. Problem with your balance?	None		Sometimes balance is off, less sure footed		Often balance is off and not sure footed

PHYSICAL FUNCTION SCALE

In the LAST MONTH, on a typical day:

1. How far have you been able to walk?	> 2 miles	> 2 blocks but < 2 miles	> 50 feet but < 2 blocks	Less than 50 feet
2. Have you taken walks outdoors or in malls for pleasure?	Yes, comfortably	Yes, but sometimes with pain	Yes, but always with pain	No
3. Have you been shopping for groceries or other items?	Yes, comfortably	Yes, but sometimes with pain	Yes, but always with pain	No
4. Have you walked around the different rooms in your house or apartment?	Yes, comfortably	Yes, but sometimes with pain	Yes, but always with pain	No
5. Have you walked from your bedroom to the bathroom?	Yes, comfortably	Yes, but sometimes with pain	Yes, but always with pain	No

SATISFACTION SCALE (If you have not had surgery please substitute the word "treatment" in place of "operation".)

How satisfied are you with:

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
1. The overall result of back operation/treatment?	[]	[]	[]	[]
2. Relief of pain following the operation/treatment?	[]	[]	[]	[]
3. Your ability to walk following the operation/treatment?	[]	[]	[]	[]
4. Your ability to do housework, yard work, or job following the operation/treatment?	[]	[]	[]	[]
5. Your strength in the thighs, legs, and feet?	[]	[]	[]	[]
6. Your balance, or steadiness on your feet?	[]	[]	[]	[]

With permission from: Stucki G, Daltroy L, Liang MH, Lipson SJ, Fossel AH, Katz JN. Measurement properties of a self-administered outcome measure in lumbar spinal stenosis. *Spine* 1996;21:796-803.