MICHIGAN SPINE SURGERY IMPROVEMENT COLLABORATIVE

MSSIC Data Registry
Lumbar Baseline
Patient Questionnaire

Patient Name: _____ **MRN:** _____ **Registry ID:** _____

Date of Questionnaire: _____

We ask that you please complete this form as fully and accurately as possible. Some questions may be difficult, but we ask that you answer them to the best of your ability. Please be sure to follow the directions in each section. Clearly print responses and mark boxes where needed.

Thank you for your time filling out this questionnaire, your answers will help us to provide the best possible spine care.

Back & Leg Pain Scale

Please describe your back and leg pain when off your pain medication. Please rate your back pain and leg pain on a scale of 0 to 10, where zero (0) would mean "no pain" and a ten (10) would mean "worst pain imaginable."

For example, describe your pain when you are off your medication, after your pain medication has worn off, when you are due to take your next pill, that is please describe how your pain would feel if you were not on pain medication.

Please rate your back pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your leg pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Overall Quality of Life (EQ-5D) © EuroQol Research Foundation
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By marking one box in each group below, please indicate which statements best describe your own health state today.

Mobility
- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

Self-Care
- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)
- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

Pain/Discomfort
- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety/Depression
- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

PROMIS short form - Physical Function *("Lumbar")*

Please respond to each question or statement by marking one box per row.	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
Are you able to run errands and shop?	☐	☐	☐	☐	☐

Walking

On a daily basis, do you generally walk…

- ☐ Independently
- ☐ With an assistive device (cane or walker)
- ☐ Do not walk (wheelchair bound)

Mood/Emotion

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day
2. Feeling down, depressed, or hopeless
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

Smoking History

Smoking

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Prefer not to answer

Pain Medication

Do you take opioid painkillers ***daily*** to control your pain? (prescription medications such as Vicodin, Lortab, Norco, hydrocodone, codeine, Tylenol #3 or #4, fentanyl, Duragesic, MS Contin, Percocet, Tylox, OxyContin, oxycodone, methadone, tramadol, Ultram, Dilaudid)

☐ Yes ☐ No

If "Yes":
How long have you been using opioid painkillers on a daily basis?

- ☐ Less than 3 weeks
- ☐ 3 weeks but less than 6 weeks
- ☐ 6 weeks but less than 3 months
- ☐ 3 months but less than 6 months
- ☐ 6 months or greater

If "Yes":
Is this use of narcotic/opioid pain medication to control the same pain for which you are planning to have back or neck surgery?

☐ Yes ☐ No

Is this back/neck problem related to…

a motor vehicle injury?
☐ Yes ☐ No ☐ Unknown

a Workers Compensation Claim?
☐ Yes ☐ No ☐ Undecided ☐ Prefer not to answer

a Liability or Disability Insurance Claim?
☐ Yes ☐ No ☐ Undecided ☐ Prefer not to answer

Employment…

Are you working?

- ☐ Yes - Full-time
- ☐ Yes - Part-time
- ☐ No
- ☐ Retired
- ☐ Volunteering
- ☐ On disability

*If "Are you working?" is "**Yes - Part-time**"; "**Retired**"; or **"No"**:*

Are you part-time, retired, or not working because of your back or neck problems?

- ☐ Yes
- ☐ No

*If **"Yes" Either "Full-time" or "Part-time**":*

Does your job require you to stand up to 6 hours per day?

- ☐ Yes
- ☐ No

Does your job require you to lift …

- ☐ Frequently more than 50 pounds
- ☐ Frequently more than 25 pounds and occasionally 50 pounds
- ☐ Frequently 10 pounds and occasionally 25 pounds
- ☐ Occasionally up to 10 pounds

Regardless of your current work status, do you plan to return to work after your surgery?

- ☐ Yes
- ☐ No
- ☐ Unknown

Additional Information…

Race/Ethnicity

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Multi-Racial/Other
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Unknown/Refused

Level of Education

- ☐ Less than High School
- ☐ High School Diploma or GED
- ☐ Two-Year College Degree
- ☐ Four-Year College Degree
- ☐ Post-College

What is your preference for future contact for this study?

- ☐ E-mails with access to web-based questionnaires - E-mail address: _____
- ☐ Telephone calls with questionnaires by interview process - Phone number: _____
- ☐ Mailings with paper questionnaires to be returned