

ATLANTIC SPINAL CARE

PATIENT QUESTIONNAIRE

Instructions: This survey asks for your views about your health. The information will help keep track of how well you are able to do your usual activities. Please answer each question by marking **one box**. If you are unsure about how to answer please give the best answer you can.

In general would you say your health is

- Excellent Very good Good Fair Poor

The following items are about activities that you might do during a typical day. Does **your health now limit** you in these activities? If so, how much?

(Fill in **one circle on each line**)

	Yes limited a lot	Yes limited a little	Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing several flights of stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

- Accomplished less than you would like. Yes No
Were limited in the kind of work or other activities. Yes No

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

- Accomplished less than you would like. Yes No
Didn't do work or other activities as carefully as usual. Yes No

During the **past 4 weeks** how much did **pain** interfere with your normal work (including work outside the home and housework)?

- Not at all A little bit Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

Patient's initials _____ Date _____