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Direction of Feed

SRS-22r Patient Questionnaire

Please answer every question

Handwritten items must be
entered **MANUALLY**.
Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month

Day

Year

INSTRUCTIONS:

We are carefully evaluating your back condition.
It is important that **YOU** answer the questions below.
Please mark only **ONE** bubble for each question.

Which best describes the amount of pain you have experienced during the past 6 months?

None
Mild

Moderate
Moderate to severe

Severe

Which best describes the amount of pain you have experienced over the last month?

None
Mild

Moderate
Moderate to severe

Severe

During the past 6 months, have you been a very nervous person?

None of the time
A little of the time

Some of the time
Most of the time

All of the time

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 happy
Somewhat happy

Neither happy nor unhappy
Somewhat unhappy

Very unhappy

What is your current level of activity?

Bedridden
Primarily no activity
Light labor and light sports

Moderate labor and moderate sports
Full activities without restriction

How do you look in clothes?

Very good

Good

Fair

Bad

Very bad

During the past 6 months, have you felt so down in the dumps that nothing could cheer you up?

Very often

Often

Sometimes

Rarely

Never

Do you experience back pain when at rest?

Very often

Often

Sometimes

Rarely

Never

What is your current level of work / school activity?

100% normal

75% normal

50% normal

25% normal

0% normal

Which 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

What best describes your pain medication use for back pain?

None
Non-narcotics weekly or less (e.g., aspirin, Tylenol, ibuprofen)
Non-narcotics daily
Narcotics weekly or less (e.g., Tylenol III, Lorcet, Percocet)
Narcotics daily

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SRS-22r Patient Questionnaire

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Does your back limit your ability to do things around the house?

Never Rarely Sometimes Often Very often

Have you felt calm and peaceful during the past 6 months?

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

Do you feel that your back condition affects your personal relationships?

None Slightly Mildly Moderately Severely

Are you and/or your family experiencing financial difficulties because of your back?

Severely Moderately Mildly Slightly None

In the past 6 months, have you felt downhearted and blue?

Never Rarely Sometimes Often Very often

In the last 3 months, have you taken any days off work, including household work, or school because of back pain?

0 days 1 day 2 days 3 days 4 or more days

Does your back condition limit your going out with friends / family?

Never Rarely Sometimes Often Very often

Do you feel attractive with your current back condition?

Yes, very Neither attractive nor unattractive No, not at all
Yes, somewhat No, not very much

Have you been a happy person during the past 6 months?

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

Are you satisfied with the results of your back management?

Very satisfied Neither satisfied nor unsatisfied Very unsatisfied
Satisfied Unsatisfied

Would you have the same management again if you had the same condition?

Definitely yes Not sure Definitely not
Probably yes Probably not

Please comment below, if you wish. Thank you for completing this questionnaire.

Blank area for handwritten comments with horizontal lines.

