MICHIGAN SPINE SURGERY IMPROVEMENT COLLABORATIVE

MSSIC Data Registry
Cervical 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.

Neck & Arm Pain Scale

Please describe your neck and arm pain when off your pain medication. Please rate your neck pain and arm 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 neck pain on a scale of 0 to 10 over the past 7 days (0 through 10): __________

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

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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

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)

Modified Japanese Orthopedic Association Myelopathy Scale (modified Chiles version)

Each of the 6 questions below has a choice of answers. Please indicate which answer best describes your own health state today.

1. Feeding and use of your hands and arms.

   Describe your ability to feed yourself.

   - ☐ Unable to feed myself
   - ☐ Unable to use both hands for knife and fork, but I am able to eat using a fork or spoon with one hand
   - ☐ Able to use a knife and fork with much difficulty
   - ☐ Able to use a knife and fork with slight difficulty
   - ☐ Able to feed myself with no difficulty using both hands

2. Walking and use of your legs. Describe your ability to walk.

   - ☐ Unable to walk
   - ☐ Can walk on flat surface with a cane or walker
   - ☐ Can walk up or down stairs with support of a handrail
   - ☐ Some trouble walking smoothly and problems with balance
   - ☐ No problem walking

3. Loss of feeling or numbness in hands and arms.

   Describe your ability to feel sensation in your hands or arms.

   - ☐ Severe loss of feeling in my hand or arm, loss of pain, touch or sensation
   - ☐ Mild loss of feeling in my hand or arm
   - ☐ No loss of feeling in my hands and arms

4. Loss of feeling or numbness in legs.

   Describe your ability to feel sensation in your legs.

   - ☐ Severe loss of feeling in my legs
   - ☐ Mild loss of feeling in my legs
   - ☐ No loss of feeling in my legs

5. Loss of feeling or numbness in the trunk of my body.

   Describe your ability to feel sensation in your body.

   - ☐ Severe loss of feeling in my body
   - ☐ Mild loss of feeling in my body
   - ☐ No loss of feeling in my body

6. Problems with urinating.

   - ☐ Cannot urinate, void, or pee
   - ☐ Severe difficulty because of feeling of residual urine or retaining urine even after voiding or because of straining to go or just dribbling when urinating
   - ☐ Mild difficulty because of problem with initiating or getting started or problem with urinating either too frequently or hardly ever
   - ☐ No problems with urinating or peeing

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

Do you smoke (use) tobacco or use nicotine-containing e-cigarettes?

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker (quit more than 30 days ago)
- ☐ 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 ☐ Retired
☐ Yes - Part-time ☐ Volunteering
☐ No ☐ 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: ____________________________________
☐ Your facility's patient portal (where you view your medical record online). Example: MyChart
☐ Telephone calls with questionnaires by interview process - Phone number: _____________________________
☐ Mailings with paper questionnaires to be returned