**SRS-22r Patient Questionnaire**

**Patient Name:** ____________  __________  ______________ **Date of Birth:** __ __ __

First                  MI               Last                   Mo     Day        Yr

**Today’s Date:** __ __ __

Mo       Day        Yr                                                  Yrs          Mo

**Medical Record #:** ___________________

**INSTRUCTIONS:** We are carefully evaluating the condition of your back and it is **IMPORTANT THAT YOU ANSWER EACH OF THESE QUESTIONS YOURSELF.** Please **CIRCLE THE ONE BEST ANSWER TO EACH QUESTION.**

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?

   None  
   Mild  
   Moderate  
   Moderate to severe  
   Severe

2. Which one of the following best describes the amount of pain you have experienced over the last month?

   None  
   Mild  
   Moderate  
   Moderate to severe  
   Severe

3. 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

**(CONTINUED ON NEXT PAGE)**
4. 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  

5. 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  

6. How do you look in clothes?
   
   Very good  
   Good  
   Fair  
   Bad  
   Very bad  

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
   
   Very often  
   Often  
   Sometimes  
   Rarely  
   Never  

8. Do you experience back pain when at rest?
   
   Very often  
   Often  
   Sometimes  
   Rarely  
   Never  

9. What is your current level of work/school activity?
   
   100% normal  
   75% normal  
   50% normal  
   25% normal  
   0% normal  

(CONTINUED ON NEXT PAGE)
10. Which of the following 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

11. Which one of the following 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

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

   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

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

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

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

   - None
   - Slightly
   - Mildly
   - Moderately
   - Severely

(CONTINUED ON NEXT PAGE)
15. Are you and/or your family experiencing financial difficulties because of your back?

   Severely
   Moderately
   Mildly
   Slightly
   None

16. In the past 6 months have you felt down hearted and blue?

   Never
   Rarely
   Sometimes
   Often
   Very often

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

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

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

   Never
   Rarely
   Sometimes
   Often
   Very often

19. Do you feel attractive with your current back condition?

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

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

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

(CONTINUED ON NEXT PAGE)
21. Are you satisfied with the results of your back management?

   Very satisfied
   Satisfied
   Neither satisfied nor unsatisfied
   Unsatisfied
   Very unsatisfied

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

   Definitely yes
   Probably yes
   Not sure
   Probably not
   Definitely not

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

3-10-06

END
TRUNK APPEARANCE PERCEPTION SCALE- (TAPS)

Maximum best score achieved if patient circles the number 5 in all three sets: $15/3 = 5$ points.

Maximum worse score achieved if patient circles the number 1 in all three sets: $3/3 = 1$ point.

hez-Raya J, Pérez-Grueso FJ Sánchez, Climent JM: The Trunk Appearance Perception Scale (TAPS):

Evaluate subjective impression of trunk deformity in patients with idiopathic scoliosis.

10, 5-6.
Patient’s Name: _______________________
Date of Birth: __________________
Height: _____________________________
Weight: ____________________________

**General Health**

- Do you smoke? Yes No
- Do you drink? Yes No
- Do you have a pacemaker? Yes No

**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? Yes No

**ALLERGIES:** ________________________________

Have you **RECENTLY** noted any of the following (check all that apply)?

- Fatigue
- Fever/chills/sweats
- Difficulty maintaining balance and/or falls
- Unexplained weight loss/gain
- Nausea/vomiting
- Changes in bowel/bladder habits

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

- Cancer
- Heart problems/Disease
- Chest pain/angina
- High blood pressure
- Circulation problems
- Blood clots
- Stroke
- Anemia/blood problems
- Bone or joint infection
- Chemical dependency
- High cholesterol
- Diabetes
- Stroke
- Anxiety
- Headache/migraine
- Low blood pressure
- Depression
- Lung problems/cough
- Arthritis
- Bladder/urinary tract infection
- Kidney problem/infection
- Sexually transmitted disease/HIV
- Thyroid problems
- Osteoporosis
- Multiple sclerosis
- Epilepsy / Seizures
- Eye problem/infection
- Ulcers / Colitis
- Liver problems/ Hepatitis
- Asthma
- Other:

Are you experiencing any of the following (check all that apply)?

- Numbness or tingling
- Muscle weakness
- Dizziness/lightheadedness
- Double Vision
- Heartburn/indigestion
- Difficulty swallowing or speaking
- Changes in bowel or bladder function
- Headaches

Please list any medications you are currently taking.
Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

**History of Present Illness**

What date (roughly) did your present problem start? _________________________________________

My symptoms are currently: Getting Better, Getting Worse, Staying about the same

Treatment received so far for this problem (chiropractic, injections, surgery, etc):

________________________________________________________

Please list special tests performed for this problem (x-ray, MRI, EMG etc)

________________________________________________________

**General Health:**

At the present time, would you say that your health is excellent, very good, fair, or poor?

Excellent      Very good      Fair      Poor

________________________________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature: ___________________________ Date: ____________