

Questionnaire for patients who are to undergo surgery for degenerative changes in the neck



Patient data		Profession (check only one box)	
Name		<input type="checkbox"/> Have a job where I work a lot with my arms above shoulder level <input type="checkbox"/> Have a job where I mostly use a computer <input type="checkbox"/> Have a job that involves heavy physical work <input type="checkbox"/> Have a job that involves light physical work with a varied working position <input type="checkbox"/> Have a sedentary job	
Date of birth/national identity number <input type="text"/>			
Mobile phone number <input type="text"/>			
Date of completion <input type="text"/>		Day	Month
		Year	
Marital status		<input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Single	
First language		<input type="checkbox"/> Norwegian <input type="checkbox"/> Sami <input type="checkbox"/> Other, specify which <hr/>	
Ethnic/cultural affiliation		<input type="checkbox"/> Norway <input type="checkbox"/> North Africa including Sahara <input type="checkbox"/> Scandinavia outside Norway <input type="checkbox"/> Sub-Saharan Africa <input type="checkbox"/> Europa outside Scandinavia <input type="checkbox"/> North America <input type="checkbox"/> Middle East <input type="checkbox"/> South and Central America <input type="checkbox"/> Asia outside Middle East <input type="checkbox"/> Oceania (Australia, New Zealand and other island communities)	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I have smoked before			
Do you use snuff/snus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I have used snuff/snus before			
Height and weight			
Height <input type="text"/> , <input type="text"/> (m)		Weight <input type="text"/> <input type="text"/> <input type="text"/> (kg)	
Education			
What is your highest level of education completed? (Check only one box)			
<input type="checkbox"/> Primary school, 7–10 years <input type="checkbox"/> Education as skilled worker (Vocational school) <input type="checkbox"/> Upper secondary school <input type="checkbox"/> University college or university (less than 4 years) <input type="checkbox"/> University college or university (4 years or more)			
Waiting time related to neck surgery			
Waiting time from when you were referred by your GP until an appointment at a specialist outpatient clinic was completed (check only one box)			
<input type="checkbox"/> Less than 3 months <input type="checkbox"/> 3–6 months <input type="checkbox"/> 6–12 months <input type="checkbox"/> More than 1 year			
Waiting time from decision to perform surgery until the operation was completed			
<input type="checkbox"/> Less than 3 months <input type="checkbox"/> 3–6 months <input type="checkbox"/> 6–12 months <input type="checkbox"/> More than 1 year			
Pain and work			
In your view, how large is the risk that your current pain may become persistent? Circle one			
No risk 0 1 2 3 4 5 6 7 8 9 10 Very large risk			
In your estimation, what are the chances you will be working your normal duties in 6 months? Circle one			
No chance 0 1 2 3 4 5 6 7 8 9 10 Very large chance			
An increase in pain is an indication that I should stop what I'm doing until the pain decreases. Circle one			
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree			
I should not do my normal work with my present pain. Circle one			
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree			

Duration of symptoms		Painkillers								
Continuous duration of current radiating arm pain (check only one box)		Do you use painkillers due to your neck– and/or shoulder pain?								
<input type="checkbox"/> I have no radiating pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
<input type="checkbox"/> Less than 3 months	If yes: How often do you use painkillers? (check only one box)									
<input type="checkbox"/> 3–12 months	<input type="checkbox"/> Less frequently than every week									
<input type="checkbox"/> 1–2 years	<input type="checkbox"/> Every week									
<input type="checkbox"/> More than 2 years	<input type="checkbox"/> Daily									
Continuous duration of current neck pain (check only one box)		<input type="checkbox"/> Several times a day								
<input type="checkbox"/> I have no neck pain	Reduced strength									
<input type="checkbox"/> Less than 3 months	Have you reduced strength in the relevant shoulder, arm or hand?									
<input type="checkbox"/> 3–12 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
<input type="checkbox"/> 1–2 years	If yes: Specify the duration as accurately as possible, using only one of the following options									
<input type="checkbox"/> More than 2 years	<input type="checkbox"/> Less than 24 hours, number of hours									
Continuous duration of current headache (check only one box)		<input type="checkbox"/> Less than 1 week, number of days.....								
<input type="checkbox"/> I have no headache	<input type="checkbox"/> 1 week to 3 month, number of weeks									
<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> 3–12 months									
<input type="checkbox"/> 3–12 months	<input type="checkbox"/> More than 12 months									
<input type="checkbox"/> 1–2 years	Neck pain disability index (Vernon-Mior)									
<input type="checkbox"/> More than 2 years	This questionnaire is designed to give the health care provider information as to how your neck pain has affected your ability to manage in your every day life. In each section, check only the ONE box that applies to you. We realize that you consider that two of the statements in any one section relates to you, but just check the one that most closely describes your problem today.									
How severe was your pain last week?										
How would you grade your headache during the last week? Circle one										
0	1	2	3	4	5	6	7	8	9	10
No pain				Worst pain imaginable						
How would you grade your neck pain during the last week? Circle one										
0	1	2	3	4	5	6	7	8	9	10
No pain				Worst pain imaginable						
How would you grade your arm pain (one or both) during the last week? Circle one										
0	1	2	3	4	5	6	7	8	9	10
No pain				Worst pain imaginable						
Where does the pain radiate? (check only one box)										
<input type="checkbox"/> In both shoulders/arms										
<input type="checkbox"/> Only in one shoulder/arm										
<input type="checkbox"/> No radiating pain										
How far out does your arm pain radiate? (check only one box)										
<input type="checkbox"/> To the shoulder										
<input type="checkbox"/> To upper arm/elbow										
<input type="checkbox"/> To forearm/wrist										
<input type="checkbox"/> To finger(s)										
<input type="checkbox"/> No pain in shoulder/arm										
Have you been examined or treated for shoulder pain in the past?										
<input type="checkbox"/> Yes	<input type="checkbox"/> No									

4. Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of moderate neck pain
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

5. Headaches

- I have no headaches at all
- I have slight headaches that come infrequently
- I have moderate headaches that come infrequently
- I have moderate headaches that come frequently
- I have severe headaches that come frequently
- I have headaches almost all of the time

6. Concentration

- I can concentrate fully when I want with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty concentrating when I want to
- I have a lot of difficulty concentrating when I want to
- I have a great deal of difficulty concentrating when I want to
- I cannot concentrate at all

7. Work

- I can do as much work as I want
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

8. Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight neck pain
- I can drive my car as long as I want with moderate neck pain
- I can't drive my car as long as I want because of moderate neck pain
- I can hardly drive at all because of severe neck pain
- I can't drive my car at all

9. Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1 to 2 hours sleepless)
- My sleep is moderately disturbed (2 to 3 hours sleepless)
- My sleep is greatly disturbed (3 to 5 hours sleepless)
- My sleep is completely disturbed (5 to 7 hours sleepless)

10. Recreation

- I am able to engage in all my recreation activities with no neck pain
- I am able to engage in all my recreation activities with some neck pain
- I am able to engage in most, but not all, of my usual recreation activities because of neck pain
- I am able to engage in a few of my usual recreation activities because of neck pain
- I can hardly do any recreation activities because of neck pain
- I can't do any recreation activities at all because of neck pain

Spinal cord function (P-mJOA)

Below you find four descriptions of different spinal cord functions. Please check the box that applies to you, only one check per section

**1. Upper extremities (arms and hands) Motor dysfunction
Choose the statement that best fits: I am.....**

- Unable to move my hands
- Unable to eat with a spoon but am able to move my hands
- Unable to button my shirt but able to eat with a spoon
- Able to button my shirt with great difficulty
- Able to button my shirt with slight difficulty
- Not having any trouble using my hands

**2. Lower extremities (legs) Motor dysfunction
Choose the statement that best fits: I am.....**

- Completely unable to move legs at all and have no feeling in legs
- Having feeling in legs but not able to move them at all
- Able to move my legs but am unable to walk
- Able to walk on flat floor with a walking aid (cane or crutch)
- Able to walk up-&/or downstairs w/aid of a handrail
- Able to walk up-&/or downstairs without handrail but I notice moderate-to-significant lack of stability/feeling of imbalance when I walk
- Able to walk unaided (no crutches, canes, walker) with smooth reciprocity (ie, legs move smoothly) but I still notice mild lack of stability/feeling of imbalance when walking
- Able to walk without any problems of imbalance or instability

**3. Upper extremities (arms and hands) Sensory dysfunction
Choose the statement that best fits: I have...**

- Complete loss of feeling in hands
- Severe loss of feeling, or have pain in my hands
- Mild loss of feeling in hands
- No loss of feeling in hands

4. Sphincter dysfunction**Choose the statement that best fits: I**

- Am completely unable to control urination
- Have marked difficulty controlling urination
- Have mild to moderate difficulty controlling urination
- No difficulty controlling urination

Health Questionnaire (EQ-5D)

Under each heading, please check the ONE box that best describes your health TODAY.

1. Mobility

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

2. Self-care

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

3. Usual activities (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

4. Pain/discomfort

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

5. Anxiety/depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

State of health

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine. 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

