

PARTICIPANTS ID:



## 6 mth Participant Questionnaire

If you need to get in touch with the ACTIVATeS Trial research team, please contact:

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**Please read these instructions before completing the questionnaire:**

Thank you for agreeing to take part in this study. The answers you give in this questionnaire will help us find out if the treatments you receive are helpful for your scoliosis.

**Please answer all the questions.** Although it may seem that questions are asked more than once, it is still important that you answer every one. We apologise for any repetition but we have used specially designed questionnaires and to assess the treatment you are receiving properly they need to be answered fully.

Please follow the instructions for each section carefully.

**Most questions request that you place an X in the box provided.** If so, please use an X rather than a tick, so that we can tell when you really meant to choose a particular box.

For example in the following question, if your answer 'yes', you should place an X firmly in the box next to yes.

	Yes	No
Do you drive a car?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Please use a **BLACK or BLUE pen**. Please do not use a pencil.

Please check that you have completed all sections and return your completed questionnaire to the research clinician.

You will be invited to complete another questionnaire in approximately 6 months time.

Please keep a record of any days off school, and hospital or medical procedures you undergo until we see you again.

Please write any notes you have for the research team on the back page.

**Section 1:**

This section is to find out some general information about you. Please answer the following questions as completely as you can.

1. Date of birth:

\_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

2. Female <sub>1</sub> Male <sub>2</sub>

3. Do you currently wear a brace for your scoliosis?

Yes <sub>1</sub>

No <sub>2</sub>

4. Onset of puberty:

Girls – have you started your periods?

Yes <sub>1</sub> No <sub>2</sub>

If yes, what age:

\_\_ \_\_ years old

Boys – have you noticed any symptoms of puberty (i.e. pubic hair, voice changes)?

Yes <sub>1</sub> No <sub>2</sub>

If yes, what age:

\_\_ \_\_ years old

**Section 2:**

1. In what way has your scoliosis changed in the past 6 months? (*Please place a cross in one box*)

Vastly improved <sub>1</sub>

Much improved <sub>2</sub>

Slightly improved <sub>3</sub>

No change <sub>4</sub>

Slightly worsened <sub>5</sub>

Much worsened <sub>6</sub>

Vastly worsened <sub>7</sub>

2. How much benefit or harm have you experienced from the advice or treatment you have received as part of the ACTivATeS Trial? *(Please place a cross in one box)*

Substantial benefit  <sub>1</sub>

Moderate benefit  <sub>2</sub>

No benefit or harm  <sub>3</sub>

Moderate harm  <sub>4</sub>

Substantial harm  <sub>5</sub>

3. How satisfied were you with the advice or treatment that you received as part of the ACTivATeS Trial?

Extremely dissatisfied  <sub>1</sub>

Very dissatisfied  <sub>2</sub>

Somewhat dissatisfied  <sub>3</sub>

Neither satisfied nor dissatisfied  <sub>4</sub>

Somewhat satisfied  <sub>5</sub>

Very satisfied  <sub>6</sub>

Extremely satisfied  <sub>7</sub>



4. Are you currently doing any exercises for your scoliosis?

Yes <sub>1</sub> go to question 5

No <sub>2</sub> go to question 6

5. If yes, how often are you doing these exercises? (please circle the closest answer)

Daily  1      3-4 times a week  2      1-2 times a week  3      Other: .....  4

6. Have you had any surgery for your scoliosis since the last time you completed this questionnaire (6 months ago)?

Yes <sub>1</sub> Please state when: \_ \_ / \_ \_ / \_ \_ \_ \_

No <sub>2</sub>

7. Have you been placed on a waiting list to have surgery for your scoliosis since the last time you completed this questionnaire (6 months ago)?

Yes <sub>1</sub>

No <sub>2</sub>

### **Section 3:**

The following questions ask about the condition of your back and how it affects you. Please place an X in the box for the best answer to each question. Please only enter one answer for each question.

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

- |                    |                          |   |
|--------------------|--------------------------|---|
| None               | <input type="checkbox"/> | 1 |
| Mild               | <input type="checkbox"/> | 2 |
| Moderate           | <input type="checkbox"/> | 3 |
| Moderate to severe | <input type="checkbox"/> | 4 |
| Severe             | <input type="checkbox"/> | 5 |

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

- |                    |                          |   |
|--------------------|--------------------------|---|
| None               | <input type="checkbox"/> | 1 |
| Mild               | <input type="checkbox"/> | 2 |
| Moderate           | <input type="checkbox"/> | 3 |
| Moderate to severe | <input type="checkbox"/> | 4 |
| Severe             | <input type="checkbox"/> | 5 |

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

- |                      |                          |   |
|----------------------|--------------------------|---|
| None of the time     | <input type="checkbox"/> | 1 |
| A little of the time | <input type="checkbox"/> | 2 |
| Some of the time     | <input type="checkbox"/> | 3 |
| Most of the time     | <input type="checkbox"/> | 4 |
| All of the time      | <input type="checkbox"/> | 5 |

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                | <input type="checkbox"/> | 1 |
| Somewhat happy            | <input type="checkbox"/> | 2 |
| Neither happy nor unhappy | <input type="checkbox"/> | 3 |
| Somewhat unhappy          | <input type="checkbox"/> | 4 |
| Very unhappy              | <input type="checkbox"/> | 5 |

5. What is your current level of activity?

- Bedridden  1
- Primarily no activity  2
- Light activities and light sports  3
- Moderate activities and moderate sports  4
- Full activities without restriction  5

6. How do you look in clothes?

- Very good  1
- Good  2
- Fair  3
- Bad  4
- Very bad  5

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?

- Very often  1
- Often  2
- Sometimes  3
- Rarely  4
- Never  5

8. Do you experience back pain when at rest?

- Very often  1
- Often  2
- Sometimes  3
- Rarely  4
- Never  5

9. What is your current level of work/school activity?

- 100% normal  <sub>1</sub>
- 75% normal  <sub>2</sub>
- 50% normal  <sub>3</sub>
- 25% normal  <sub>4</sub>
- 0% normal  <sub>5</sub>

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  <sub>1</sub>
- Good  <sub>2</sub>
- Fair  <sub>3</sub>
- Poor  <sub>4</sub>
- Very Poor  <sub>5</sub>

11. Which one of the following best describes your pain medication use for back pain?

- None  <sub>1</sub>
- Non-narcotics weekly or less (e.g., aspirin, paracetamol, Ibuprofen)  <sub>2</sub>
- Non-narcotics daily  <sub>3</sub>
- Narcotics weekly or less (e.g. codydramol, co-codamol)  <sub>4</sub>
- Narcotics daily  <sub>5</sub>

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

- Never  <sub>1</sub>
- Rarely  <sub>2</sub>
- Sometimes  <sub>3</sub>
- Often  <sub>4</sub>
- Very Often  <sub>5</sub>

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

- All of the time  1
- Most of the time  2
- Some of the time  3
- A little of the time  4
- None of the time  5

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

- Not at all  1
- Slightly  2
- Mildly  3
- Moderately  4
- Severely  5

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

- Severely  1
- Moderately  2
- Mildly  3
- Slightly  4
- Not at all  5

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

- Never  1
- Rarely  2
- Sometimes  3
- Often  4
- Very often  5

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         | <input type="checkbox"/> | 1 |
| 1 day          | <input type="checkbox"/> | 2 |
| 2 days         | <input type="checkbox"/> | 3 |
| 3 days         | <input type="checkbox"/> | 4 |
| 4 or more days | <input type="checkbox"/> | 5 |

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

- |            |                          |   |
|------------|--------------------------|---|
| Never      | <input type="checkbox"/> | 1 |
| Rarely     | <input type="checkbox"/> | 2 |
| Sometimes  | <input type="checkbox"/> | 3 |
| Often      | <input type="checkbox"/> | 4 |
| Very often | <input type="checkbox"/> | 5 |

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

- |                                     |                          |   |
|-------------------------------------|--------------------------|---|
| Yes, very                           | <input type="checkbox"/> | 1 |
| Yes, somewhat                       | <input type="checkbox"/> | 2 |
| Neither attractive nor unattractive | <input type="checkbox"/> | 3 |
| No, not very much                   | <input type="checkbox"/> | 4 |
| No, not at all                      | <input type="checkbox"/> | 5 |

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

- |                      |                          |   |
|----------------------|--------------------------|---|
| None of the time     | <input type="checkbox"/> | 1 |
| A little of the time | <input type="checkbox"/> | 2 |
| Some of the time     | <input type="checkbox"/> | 3 |
| Most of the time     | <input type="checkbox"/> | 4 |
| All of the time      | <input type="checkbox"/> | 5 |

21. Are you satisfied with the results of your back management?

Very satisfied  1

Satisfied  2

Neither satisfied nor unsatisfied  3

Unsatisfied  4

Very unsatisfied  5

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

Definitely yes  1

Probably yes  2
















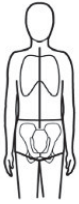
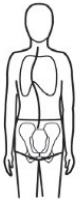
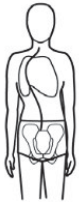







Not sure  3

Probably not  4

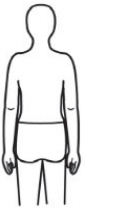
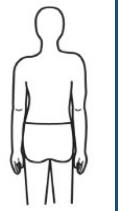
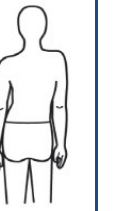
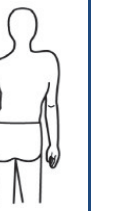
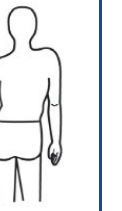






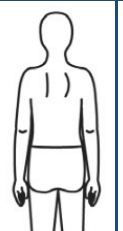
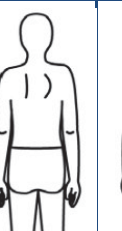


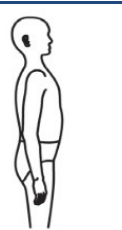
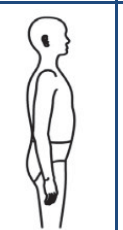
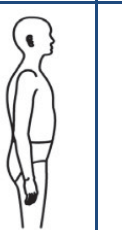
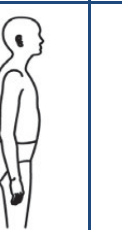
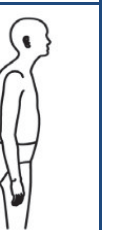


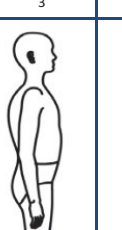


Definitely not  5

**Section 4**

Please look carefully at the following pictures that describe spinal shapes. Please place an X in the box below the drawing that looks most like you.

<p>1. Body curve</p>					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<p>2. Rib prominence (bump)</p>					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<p>3. Flank prominence (bump)</p>					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<p>4. Head chest hips</p>					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<p>5. Position of head over hips</p>					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



6. Shoulder level					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Shoulder blade rotation					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Shoulder angle					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. Head position					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Spine prominence (bump)					
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please tell us how well the following statements apply to you. Please mark the box with an X that most applies to you.

	Not true	A little true	Somewhat true	Fairly true	Very true
11. I want to be more even.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
12. I want to look better in clothes.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
13. I want to have more even hips.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
14. I want to have a more even waist.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## Section 5

Listed below are a number of statements related to a variety of normal kinds of feelings and bodily reactions. Read each item and decide how well the statement reflects you personally. It's best to go with your first judgement and not to spend too long thinking about any one question.

Place a 'X' in the box that most applies to you.

	Never true	Occasionally true	Sometimes true	Frequently true	Always true
1. I am aware of my overall body posture.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. I am aware of how far I am bending over when I have to bend to do something.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. I am aware of strain in my muscles.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. I can provide definite information regarding the specific location and severity of pain/ discomfort in my body when the doctor asks me what symptoms I am having.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. I can exert the correct amount of force/ pressure required to do a task even without thinking about it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. I am sensitive to changes in the position of my legs even without looking at them.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. I can touch my nose with my index fingers, even with my eyes closed.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. I can tell when I should stop doing something (e.g. lifting) before it causes me pain or injury.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. I can tell where my hands are located without even looking at them.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. I can tell how tired I will be after a task when I first start doing it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. I can feel even the slightest touch (e.g. a small raindrop or an ant crawling) on my skin.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. I know my own strength.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

## Section 6

Some kind of problems can make it hard to do many activities, such as eating, bathing, school work, and playing with friends. We would like to find out how you are doing. Please answer all questions by writing an X in the box that most applies to you.

1. During the last week was it easy or hard for you to:

	Easy	A little hard	Very hard	Can't do at all
Lift heavy books?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Pour a 2 litre bottle of milk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Open a jar that has been opened before?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Use a fork and spoon?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Comb your hair?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Button buttons?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Put on your coat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Write with a pencil?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

2. On average, over the last 12 months, how often did you miss school because of your health?

Rarely	<input type="checkbox"/> <sub>1</sub>
Once a month	<input type="checkbox"/> <sub>2</sub>
Two or three times a month	<input type="checkbox"/> <sub>3</sub>
Once a week	<input type="checkbox"/> <sub>4</sub>
More than once a week	<input type="checkbox"/> <sub>5</sub>
Do not attend school, etc.	<input type="checkbox"/> <sub>6</sub>

3. During the last week how happy have you been with:

	Very happy	Somewhat happy	Not sure	Somewhat unhappy	Very unhappy
How you look?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Your body?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
What clothes or shoes you can wear?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Your ability to do the same things your friends do?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Your health in general?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

4. During the last week, how much of the time

	Most of the time	Some of the time	A little of the time	None of the time
Did you feel sick and tired?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Were you full of pep and energy?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Did pain or discomfort interfere with your activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

5. During the last week has it been easy or hard for you to:

	Easy	A little hard	Very hard	Can't do at all
Run short distances?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Ride a bike?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Climb three flights of stairs?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Climb one flight of stairs?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Walk more than a mile?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Walk three blocks ?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Walk one block ?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Get on and off a bus?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

6. How often do you need help from another person for walking and climbing?

Never	Sometimes	About half the time	Often	All the time
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

7. How often do you use assistive devices (such as braces, crutches, or wheelchair) for walking and climbing?

Never	Sometimes	About half the time	Often	All the time
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

8. During the last week has it been easy or hard for you to:

	Easy	A little hard	Very hard	Can't do at all
Stand while washing your hands and face at a sink?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Sit in a regular chair without holding on?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Get on and off a toilet or chair?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Get in and out of bed?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Turn door knobs?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Bend over from a standing position and pick up something off the floor?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

9. How often do you need help from another person for sitting and standing? (Cross (x) one box.)

Never	Sometimes	About half the time	Often	All the time
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

10. How often do you use assistive devices (such as braces, crutches, or wheelchair) for sitting and standing?

Never	Sometimes	About half the time	Often	All the time
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

11. Can you participate in recreational outdoor activities with other kids the same age? (For example: cycling, skating, hiking, jogging)

Yes, easily

Yes, but a little hard

Yes, but very hard

No

If you answered "no" to Question 11 above, was your activity limited by: (Cross (x) to all that apply)

Pain?

General Health?

Doctor or parent Instructions?

Fear the other kids won't like you?

Dislike of recreational outdoor activities?

Activity not in season?

12. Can you participate in games or sports with other kids the same age? (For example: tag, basketball, rounders, football, catch, skipping, touch rugby, hop scotch)

Yes, easily

Yes, but a little hard

Yes, but very hard

No

If you answered "no" to Question 12 above, was your activity limited by: (Cross (x) to all that apply)

Pain?

General Health?

Doctor or parent Instructions?

Fear the other kids won't like you?

Dislike of games or sports?

Activity not in season?



13. Can you participate in competitive level sports with other kids the same age? (For example: hockey, basketball, soccer, rugby, baseball, swimming, running [track or cross country], gymnastics, or dance)

Yes, easily

Yes, but a little hard

Yes, but very hard

No

If you answered "no" to Question 13 above, was your activity limited by: (Cross (x) to all that apply)

Pain?

General Health?

Doctor or parent Instructions?

Fear the other kids won't like you?

Dislike of competitive level sports?

Activity not in season?

14. How often in the last week did you get together and do things with friends?

Often

Sometimes

Never or rarely

If you answered "sometimes" or "never or rarely" to Question 14 above, was your activity limited by: (Cross (x) to all that apply)

Pain?

General Health?

Doctor or parent Instructions?

Fear the other kids won't like you?

Friends not around?

15. How often in the last week did you participate in PE or break time?

Often

Sometimes

Never or rarely

No gym or recess

 <sub>1</sub> <sub>2</sub> <sub>3</sub> <sub>4</sub>

If you answered "sometimes" or "never or rarely" to Question 15 above, was your activity limited by:  
(Cross (x) to all that apply)

Pain?

General Health?

Doctor or parent Instructions?

Fear the other kids won't like you?

Dislike of PE or break time?

School not in session?

I don't attend school?

16. Is it easy or hard for you to make friends with kids your own age?

Usually easy

Sometimes easy

Sometimes hard

Usually hard

 <sub>1</sub> <sub>2</sub> <sub>3</sub> <sub>4</sub>

17. How much pain have you had during the last week? (Cross (x) one box.)

None

Very mild

Mild

Moderate

Severe

Very severe

 <sub>1</sub> <sub>2</sub> <sub>3</sub> <sub>4</sub> <sub>5</sub> <sub>6</sub>

18. During the last week, how much did pain interfere with your normal activities (Including at home, outside of the home, and at school)? (Cross (x) one box.)

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

19. What expectations do you have for your treatment? As a result of my treatment, I expect:

	Definitely yes	Probably yes	Not sure	Probably not	Definitely not
To have pain relief	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To look better	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To feel better	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To feel better about myself	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To sleep more comfortably	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To be able to do activities at home	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To be able to do more at school	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To be able to do more play or recreational activities (biking, walking, doing things with friends).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To be able to do more sports	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
To be free from pain or disability as an adult	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

20. If you had to spend the rest of your life with your bone and muscle condition as it is right now, how would you feel about it?

Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## **Section 7**

By placing a X in 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

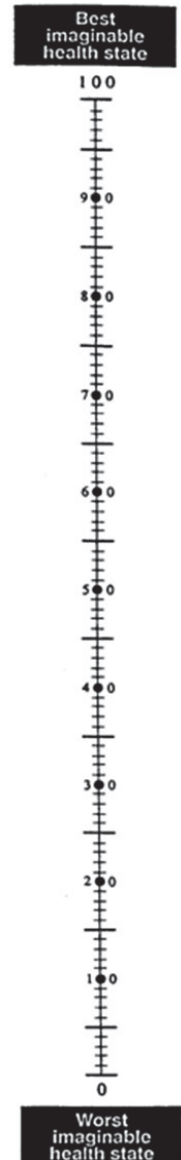
I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a Thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

We would like you to indicate on this scale **how good or bad is your own health today**, in your opinion.

Please do this by drawing a line from the box below, to whichever point on the scale indicates how good or bad your current health state is today.

Your own health state  
TODAY



## Section 8

This section asks about how your health interferes with your everyday life. Please read each question carefully and place a X in the box of the answer that best describes your level of ability. You may feel that some of these questions are repeating what we have already asked you, or that they do not apply to you, but it is important that we ask the same questions of everyone, so we would be very grateful if you would answer all the following questions.

1. Which one of the following best describes your usual ability to see well enough to read ordinary newspaper print?

Able to see well enough without glasses or contact lenses

Able to see well enough with glasses or contact lenses

Unable to see well enough even with glasses or contact lenses

Unable to see at all

2. Which one of the following best describes your usual ability to see well enough to recognise a friend on the other side of the street?

Able to see well enough without glasses or contact lenses

Able to see well enough with glasses or contact lenses

Unable to see well enough even with glasses or contact lenses

Unable to see at all

3. Which one of the following best describes your usual ability to hear what was said in a group conversation with at least 3 other people?

Able to hear what was said without a hearing aid

Able to hear what was said with a hearing aid

Unable to hear what was said even with a hearing aid

Unable to hear what was said, but did not wear a hearing aid

Unable to hear at all

4. Which one of the following best describes your usual ability to hear what was said in a conversation with one other person in a quiet room?

- Able to hear what was said without a hearing aid  1
- Able to hear what was said with a hearing aid  2
- Unable to hear what was said even with a hearing aid  3
- Unable to hear what was said, but did not wear a hearing aid  4
- Unable to hear at all  5

5. Which one of the following best describes your usual ability to be understood when speaking your own language with people who do not know you?

- Able to be understood completely  1
- Able to be understood partially  2
- Unable to be understood  3
- Unable to speak at all  4

6. Which one of the following best describes your usual ability to be understood when speaking with people who know you well?

- Able to be understood completely  1
- Able to be understood partially  2
- Unable to be understood  3
- Unable to speak at all  4

7. Which one of the following best describes how you usually feel?

- Happy and interested in life  1
- Somewhat happy  2
- Somewhat unhappy  3
- Very unhappy  4
- So unhappy that life was not worthwhile  5

8. Which one of the following best describes your usual level of pain and discomfort?

- Free of pain and discomfort  1
- Mild to moderate pain or discomfort that prevented no activities  2
- Moderate pain or discomfort that prevented some activities  3
- Moderate to severe pain or discomfort that prevented some activities  4
- Severe pain or discomfort that prevented most activities  5

9. Which one of the following best describes your usual ability to walk?

*(Note: Walking equipment refers to mechanical supports such as braces, cane, crutches, or a walker.)*

- Able to walk around the neighbourhood without difficulty, and without walking equipment  1
- Able to walk around the neighbourhood with difficulty, but did not require walking equipment or the help of another person  2
- Able to walk around the neighbourhood with walking equipment, but without the help of another person  3
- Able to walk only short distances with walking equipment, and required a wheelchair to get around the neighbourhood  4
- Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and required a wheelchair to get around the neighbourhood  5
- Unable to walk at all  6



10. Which one of the following best describes your usual ability to use your hands & fingers?

(Note: Special tools refers to hooks for buttoning clothes, gripping devices for opening jars or lifting small items, and other devices to compensate for limitations of hands or fingers.)

Full use of two hands and ten fingers

 1

Limitations in the use of hands or fingers, but did not require special tools or the help of another person

 2

Limitations in the use of hands or fingers, independent use of special tools (did not require the help of another person)

 3

Limitations in the use of hands or fingers, required the help of another person for some tasks (not independent even with the use of special tools)

 4

Limitations in the use of hands or fingers, required the help of another person for most tasks (not independent even with the use of special tools)

 5

Limitations in the use of hands or fingers, required the help of another person for all tasks (not independent even with use of special tools)

 6

11. Which one of the following best describes your usual ability to remember things?

Able to remember most things

 1

Somewhat forgetful

 2

Very forgetful

 3

Unable to remember anything at all

 4

12. Which one of the following best describes your usual ability to think & solve day to day problems?

Able to think clearly and solve day to day problems

 1

Had a little difficulty when trying to think and solve day to day problems

 2

Had some difficulty when trying to think and solve day to day problems

 3

Had great difficulty when trying to think and solve day to day problems

 4

Unable to think or solve day to day problems

 5

13. Which one of the following best describes your usual ability to perform basic activities?

- Eat, bathe, dress and use the toilet normally  1
- Eat, bathe, dress or use the toilet independently with difficulty  2
- Required mechanical equipment to eat, bathe, dress or use the toilet independently  3
- Required the help of another person to eat, bathe, dress or use the toilet  4

14. Which one of the following best describes how you usually feel?

- Generally happy and free from worry  1
- Occasionally fretful, angry, irritable, anxious, or depressed  2
- Often fretful, angry, irritable, anxious or depressed  3
- Almost always fretful, angry, irritable, anxious or depressed  4
- Extremely fretful, angry, irritable, anxious or depressed; to the point of needing professional help  5

15. Which one of the following best describes your usual level of pain or discomfort?

- Free of pain and discomfort  1
- Occasional pain or discomfort. Discomfort relieved by non-prescription drugs or self-control activity without disruption of normal activities  2
- Frequent pain or discomfort. Discomfort relieved by oral medicines with occasional disruption of normal activities  3
- Frequent pain or discomfort, frequent disruption of normal activities. Discomfort required prescription narcotics for relief  4
- Severe pain or discomfort. Pain not relieved by drugs and constantly disrupted normal activities  5

16. Overall, how would you rate your usual health?

- |           |                          |   |
|-----------|--------------------------|---|
| Excellent | <input type="checkbox"/> | 1 |
| Very good | <input type="checkbox"/> | 2 |
| Good      | <input type="checkbox"/> | 3 |
| Fair      | <input type="checkbox"/> | 4 |
| Poor      | <input type="checkbox"/> | 5 |

17. How did you complete the questionnaire? Please select the one answer that best describes your situation.

By myself, the patient/subject, without any help from anyone else  1

By myself, the patient/subject, except someone else circled the answers on the questionnaire form for me  2

By myself, the patient/subject, but with the help of someone else  3

This questionnaire was completed by a family member, without help from the subject/patient  4

This questionnaire was completed by a nurse or other health professional, without help from the subject or patient

Please specify type of health professional:  5

\_\_\_\_\_

This questionnaire was completed by another person, without help from the subject/patient

Please specify relationship to subject or patient:  6

\_\_\_\_\_

**Section 9**

This section asks about any health or social care you have accessed in the last 6 months.

Have you used or had contact with any of the following community based health or social care services in the last 6 months? Yes  <sub>1</sub>

No  <sub>2</sub>

If yes, please complete the table below:

Community based health or social care services	Used or had contact with in the last 6 months (please place a X in the box)?	Number of times in the last 6 months
GP (family doctor), surgery visit	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
GP (family doctor), home visit	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
GP (family doctor), phone/email	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Practice or district nurse	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Physiotherapist	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Occupational therapist	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Orthotist	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Social worker	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
<p>Any other community based health or social care services?</p> <p>Please specify: _____</p> <p>Please specify: _____</p> <p>Please specify: _____</p>	<p>Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub></p> <p>Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub></p> <p>Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub></p>	

2. Have you stayed overnight in an NHS hospital in the last 6 months? Yes  1

No  2

If yes, please complete the table below:

Name of hospital:	Type of ward: (e.g. children's ward)	How many nights did you stay?	Reason for stay: (e.g. to have an operation)	If you had an operation please state what type:

3. Have you visited an NHS hospital as an outpatient in the last 6 months? Yes  1

No  2

If yes, please complete the table below:

NHS Hospital departments (please place a X in the box)	Name of hospital	Number of visits in the last 6 months
Orthopaedic/spinal clinic Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2		
Paediatric clinic Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2		
Emergency department Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2		
Physiotherapy department Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2		
Orthotics/bracing department Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2		
Other department Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Please specify: _____		
Other department Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Please specify: _____		

4. Have you had any tests or investigations at an NHS hospital in the last 6 months?

Yes <sub>1</sub> No <sub>2</sub>

If yes, please complete the table below:

Test or investigations (please place a X in the box)	Number of times in the last 6 months
X-Ray Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
MRI Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
CT-Scan Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Blood Test Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Other tests or investigations Please specify: _____ Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Other tests or investigations Please specify: _____ Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	

5. Have you been prescribed any medicines (e.g. painkillers such as ibuprofen or paracetamol) by the by the NHS in the last 6 months?

Yes <sub>1</sub> No <sub>2</sub>

If yes, please provide details:

Medicine prescribed	Number of times it was prescribed in the last 6 months
1	
2	
3	
4	

6. Have you been provided with any equipment (e.g. brace or special chair) by the NHS in the last 6 months?

Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please provide details:

Type of equipment provided	Number of items in the last 6 months
1.	
2.	
3.	
4.	

7. Have your parents paid for any private healthcare (e.g. consultation with private orthopaedic consultant) because of your health in the last 6 months?

Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please provide details.

Type of private healthcare (e.g. visit to a spinal surgeon or physiotherapy treatment)	Number of visits in the last 6 months	Total cost paid by your parents	Total cost paid by medical insurance
1.			
2.			
3.			
4.			

8. Have your parents paid for any medicines (e.g. painkillers such as ibuprofen or paracetamol) because of your health in the in the last 6 months?

Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please provide details:

Type of medicine privately paid for (e.g. paracetamol)	Cost in the last 6 months (to the nearest pound)
1.	
2.	
3.	
4.	

9. Have your parents paid for any special equipment (e.g. brace or special chair) because of your health in the last 6 months?

Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please provide details:

Type of equipment paid for	Cost in the last 6 months (to the nearest pound)
1.	
2.	
3.	
4.	



**Section 10**

This section asks about education and employment

1. Are you in full-time education?

Yes <sub>1</sub> No <sub>2</sub>

If yes, then please complete questions 2- 4. If no, please proceed to Question 5.

2. What year are you in at school or college? \_\_\_\_\_

3. Have you used any additional educational services because of problems with your health in the last 6 months?

Yes <sub>1</sub> No <sub>2</sub>

If yes, please provide details.

Additional education services	Number of times in the last 6 months
Contacts with school nurse Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Contacts with school counselor Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	
Extra help in school (mentor, teaching assistant) Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub>	Total number of hours week:
Any other additional educational services Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>2</sub> Please specify: _____	

4. Have you been off school because you were sick in the last 6 months?

Yes  <sub>1</sub> No  <sub>2</sub>

If yes, how long were you off school for? Total number of days \_\_\_\_\_

**Proceed to question 7.**

5. If you are not in full-time education, which of these best describes your situation?

Activity during the day	Place an X in the box that best describes your situation
In an apprenticeship (e.g. to be a plumber, hair-dresser, etc.) or government supported training	1
Employee/Self-employed	2
Employee on sick leave	3
Unpaid employment (e.g. voluntary job)	4
Unemployed	5
Other (e.g. excluded from school)	6

6. Have you been off work because you were sick in the last 6 months? Yes  <sub>1</sub> No  <sub>2</sub>

If yes, how long were you off work for? Total number of days \_\_\_\_\_

Have you lost any earnings from your job due to sickness? Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please estimate the amount lost in the last 6 months (to the nearest pound) £\_\_\_\_\_

\_\_\_\_\_

7. Do you have a job at the weekend and/or in the holidays? Yes  <sub>1</sub> No  <sub>2</sub>

If yes, have you been off sick in the last 6 months from this job? Yes  <sub>1</sub> No  <sub>2</sub>

If yes, how long were you off work for? Total number of days \_\_\_\_\_

Have you lost any earnings from your job due to sickness? Yes  <sub>1</sub> No  <sub>2</sub>

If yes, please estimate the amount lost in the last 6 months (to the nearest pound) £\_\_\_\_\_





7. What is your partner's annual income?

- Up to £5,199  1
- £5,200 up to £10,399  2
- £10,400 up to £15,599  3
- £15,600 up to 20,799  4
- £20,800 up to 25,999  5
- £26,000 up to £31,199  6
- £31,200 up to £36,399  7
- £36,400 up to £51,599  8
- £52,000 and above  9

Is this before or after tax?

Before  1 After  2

8. How many days have they been absent from work in the last 6 months?

-----

Of these, how many were due to your child's health?

-----

9. Has your child's health affected their working ability? Yes  1 No  1

If yes: How many hours less have you worked per week due to your child's health?

-----

10. Did you spend any money on travel to access health services or visit the hospital as a result of your child's health in the last 6 months?

Yes <sub>1</sub> No <sub>2</sub>

If yes, please provide details:

	Total cost in the last 6 months (£)
Car park fees	
Petrol/fuel costs	
Public transport fares	
Taxi fares	
Other (please specify):	

11. In the last 6 months, have you incurred any other additional expenditure due to your child's health?

Yes <sub>1</sub> No <sub>2</sub>

If yes, please record any additional expenditures incurred over the last 6 months

Type of additional expenditure (e.g, exercise equipment or special clothing)	Total cost in the last 6 months (£)
1.	
2.	
3.	
4.	

Are you happy for the Research Clinician to repeat the physical tests that you did on your first visit? (e.g. balance, weight , height etc)

Yes

1

No

2

**That is the end of this questionnaire.**

Please check that you have completed all sections and return your completed questionnaire to the research clinician.

**You will be asked to complete another questionnaire in approximately 6 months.**

PARTICIPANTS ID:



## 6 mth Followup Assessment Form

If you need to get in touch with the ACTivATeS Trial research team, please contact:

ACTivATeS Trial team  
Warwick Clinical Trials Unit  
University of Warwick  
Gibbet Hill Campus  
Coventry  
CV4 7AL

Phone:   
Fax:   
E-mail:

**Warwick**  
Medical School  
CLINICAL TRIALS UNIT





**Section 1:** This section relates to information about the participant provided from x-ray that you will need to collect prior to the assessment appointment.

Please ensure you have entered the participant's ID number on the front cover of this form.

1. Date of x-ray

D	D

M	M

Y	Y	Y	Y

**2. Curve characteristics**

Type of curve (Place an X in the appropriate answer)	Apex of curve (specify level or levels as appropriate)	Cobb angle (degrees)	Direction of curve ( = left ) = right
Single <input type="checkbox"/> 1			
Double <input type="checkbox"/> 2			
Curve balance (Central Sacral Vertebral Line)	<b>Coronal plane</b> distance from S1 to plumb line C7 plumbline left of S1 = L C7 plumbline right of S1 = R	L / R <i>(please circle)</i> mm	
	<b>Sagittal plane</b> distance from S1 to plumb line C7 plumbline anterior to S1 +ve C7 plumbline posterior to S1 -ve	+ / - <i>(please circle)</i> mm	

**3. Skeletal maturity**

Please circle the number that indicates the Risser sign for this patient (from x-ray report).

0                      1                      2                      3                      4                      5

**Section 2:** This section is to ensure the research team have sufficient details about the assessment that you are performing.

1. Date you are completing this assessment:

D	D	M	M	Y	Y	Y	Y

2. Time that you began completing this assessment (24 hour clock):

H	H	M	M

3. Centre:

--

4. Research clinician's name:

--

---

### Section 3: Line bisection test

**Equipment:**

Line bisection test papers (13 in total including example - labelled in order of testing)

Pen

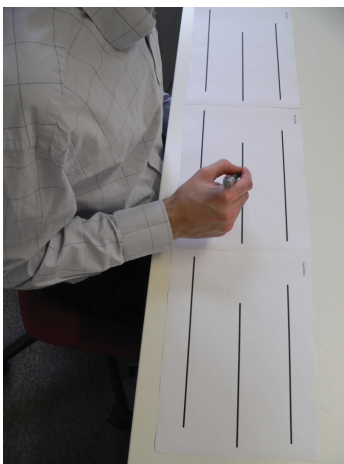
Table or similar wide enough for three A4 sheets in a line (landscape orientation)

**Set up:**

Patient sitting at table or desk.

**Procedure:**

Refer to manual for full details of testing procedure. There are two tests - one using 3 sets of straight lines and the other using 1 line on a drawing of a body. The position (left, centre or right), hand (left or right) and order of testing is described on the top of each sheet. Place one sheet down at a time and then remove it before placing the next one. The photos below illustrate the position of the sheets - in reality, only one sheet will be down at any one time.



**Instructions:**

***Straight line***

“I am going to put a sheet of paper in front of you with 3 lines on it. I want you to draw a line where you think the middle of each line is. Try to be as exact as possible”

“You will do this 3 times with your right hand and 3 times with your left. I will place the sheets in different positions. Please mark the lines with the sheet in this position - do not move it from where I put it.”

***Body line***

“I am going to put a sheet of paper in front of you with 1 line on it. I want you to draw a line where you think the middle of the line is. Try to be as exact as possible”

“You will do this 3 times with your right hand and 3 times with your left. I will place the sheets in different positions. Please mark the lines with the sheet in this position - do not move it from where I put it.”

## Section 4: Physical details

### 1. Height and weight

Standing height	cm
-----------------	----

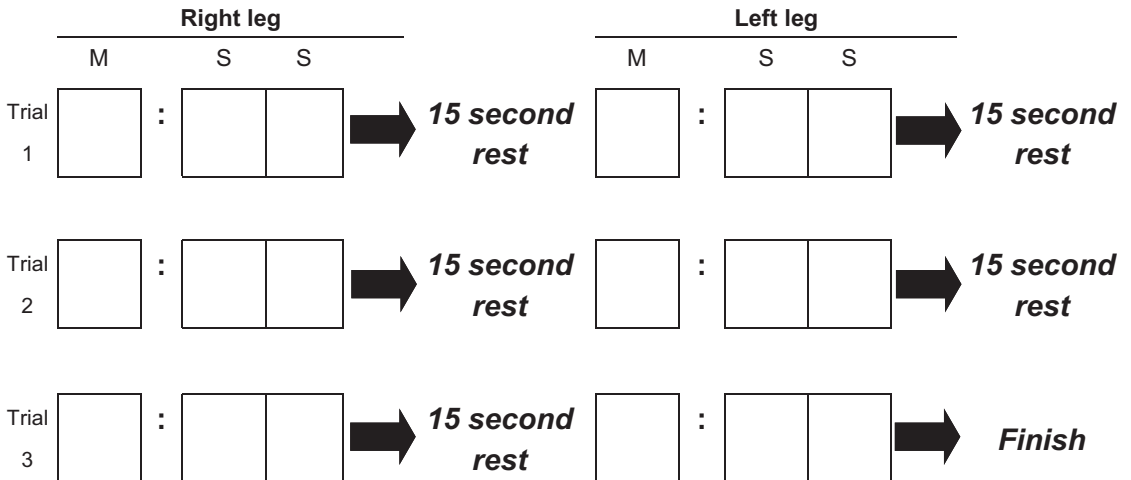
Weight	kg
--------	----

Sitting height	cm
Chair height (floor to seat)	cm

***If possible use the same stadiometer, scales and chair each time***

### 2. Balance - Timed dynamic standing balance test

Test legs **alternately (R - L - R - L - R - L)** with a **15 second rest** in between each leg to reduce fatigue.



## Section 5: Laterality discrimination (Recognise programme)

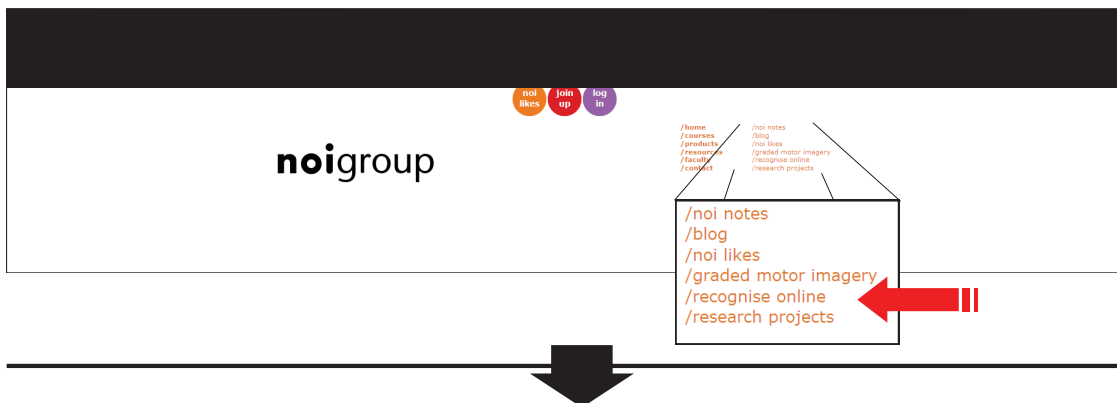
### Equipment:

Computer with internet access

### Set up:

Patient sitting at table/desk in front of computer.

1) Connect to the internet and navigate to the NOI Recognise website (www.noigroup.com/recognise).



2) Login using 3-digit participant ID number (e.g. 004@activates.com)

Enter password ('peter')

Enter 'PH1250' in 'Connect with a clinician' box.

The image shows a login form with the following fields and options:

- Log in**
- email:
- password:
- I agree to the [terms & conditions](#)
- [forgotten something?](#)
- 

The image shows a user profile page for 'test04 activates'. The page includes the following information:

- new clinician request
- Welcome test04!
- test04 activates
- test04@activates.com
- England
- 12:42am
- Account type: Trial
- First log in: 26 September 2012
- Expiry: 4 more log ins
- [/Edit details](#)
- [/Edit email and password](#)
- buy full version
- Upgrade to the full version or buy a clinicians pack. Once you're on a full version you can change your account to a clinician.
- 
- Connect with a clinician
- If your clinician has a Recognise account, enter their clinician's details below to get connected and allow your clinician access to your results. All your personal information (except name and email) and any notes will remain private. Your clinician's ID will be in a AA1234 format.
- 

3) Click '/connect' to confirm clinician. Click on 'recognise' in menu top right of screen.

The image shows a dialog box titled 'confirm your clinician'. The text inside reads: 'Please confirm that the clinician below is yours.' Below this, the following information is displayed:

- Peter Heine**
- university of warwick
- [/connect](#)
- [/no thanks](#)

The image shows a menu titled 'recognise' with the following options:

- recognise
- results
- notes
- account
- my pictures
- logout

4) Choose options for hand or back test as detailed in manual. Refer to manual for full details.

### Order of testing is provided over leaf.

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ISRCTN90480705

## **Instructions:**

### ***Hand test - Left or Right hand***

“When you start the programme, there will be a series of images of the hand in different positions. I want you to try and guess whether it is the left or the right hand.”

“Press the ‘a’ or ‘d’ key (or use arrow keys) on the keyboard to make your choice as quickly as possible. You only get one chance for each picture. The computer will tell you at the end how many you got correct. It will also time you to see how long it takes to make your decision. Try to do the test as quickly and accurately as possible.”

“Follow the instructions on the screen.”

### ***Trunk Test - moving towards the Left or Right***

“When you start the programme, there will be a series of images of the trunk in different positions. I want you to try and guess in which direction the body is moving - to the left or to the right.

“Press the ‘a’ or ‘d’ key (or use arrow keys) on the keyboard to make your choice as quickly as possible. You only get one chance for each picture. The computer will tell you at the end how many you got correct. It will also time you to see how long it takes to make your decision. Try to do the test as quickly and accurately as possible.”

“Follow the instructions on the screen.”

## Test order

1. Hands

2. Back

## **Section 6: Position matching**

### **Equipment:**

Inclinometer

Blindfold goggles

Eyeline pencil or similar (to mark measuring point)

### **Set up:**

- 1) Patient sitting on stool or bed (no back or arm rest) with feet flat on floor and arms crossed across chest so fingers are touching opposite shoulders.
- 2) Mark measuring position on skin at C7/T1 (see skin marking protocol for locating this point). Draw a line perpendicular to the spine through this point. You will use this to align the inclinometer when measuring.
- 3) Place blindfold goggles on patient and ensure they cannot see.

### **Procedure:**

Do a practice to familiarise the patient with the test procedure.

#### ***Maximum Side Flexion***

- 1) Ask patient to sit in upright position facing straight ahead with arms crossed over chest. Place the inclinometer against the skin marker at C7 and 'zero' the device.
- 2) Ask the patient to bend to one side as far as possible while keeping their legs and hips still. Measure the angle and record to nearest degree.

#### ***1/2 side flexion***

- 1) Instruct patient as to the testing procedure (i.e. attempting to match 1/2 way position).
- 2) Use the same setup as previously.
- 3) In upright position, place the device and zero it.
- 4) Ask patient to bend sideways slowly to what they consider to be 1/2 of their full side flexion ROM. Ask the patient to hold this position and to 'memorise' it. Measure the angle to the nearest degree and record it. The aim is to return to this 1/2 way position.
- 5) Return to start position.
- 6) Ask patient to return to their '1/2 way' position. Re-measure and record the angle on the display.
- 7) Repeat this 3 times for that side.

**Repeat the above procedures for the other side. The actual order of testing has been randomised (see results table).**

## **Instructions:**

### **Max ROM**

“Sit comfortably with your arms across your chest like this. I will put a blindfold over your eyes so you can’t see and then ask you to bend sideways like this. ”

“To start, you need to face straight ahead and sit comfortably - this is your start position. When I say go back to the start, this is the position you need to return to.”

“I will ask you to bend to the side as far as you can and then return to sitting straight. I will be looking at the device and writing down how far you bend. To give me time to write them down, you need to stay in the position until I say.”

“Bend your head and body together as far to the [L/R] as possible - hold that position. Return to the start position.”

### **1/2 ROM**

“Now bend your body to the [L/R] to a point you think is 1/2 way between the start position and the furthest you can go - hold that position. I want you to memorise this position because I am going to ask you to repeat it.”

“Return to the start position - now try and go back to the 1/2 way position again.”



1. mark the position of C7.

2. place the device on the line & zero inclinometer.

3. measure & record the angle at either full or 1/2 side flexion.



## Right

<b>Max Right</b>	<i>Please 'zero' the device in neutral.</i>	<b>Max side flexion Right</b>		
		degrees		

<b>1</b> <b>1/2 Right</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Right</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Right</b>
		<b>1.1</b>		<b>1.2</b>
		degrees		degrees

<b>2</b> <b>1/2 Right</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Right</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Right</b>
		<b>2.1</b>		<b>2.2</b>
		degrees		degrees

<b>3</b> <b>1/2 Right</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Right</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Right</b>
		<b>3.1</b>		<b>3.2</b>
		degrees		degrees

# Left

<b>Max Left</b>	<i>Please 'zero' the device in neutral.</i>	<b>Max side flexion Left</b>		
		degrees		

<b>1</b> <b>1/2 Left</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Left</b> <b>1.1</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Left</b> <b>1.2</b>
		degrees		degrees

<b>2</b> <b>1/2 Left</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Left</b> <b>2.1</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Left</b> <b>2.2</b>
		degrees		degrees

<b>3</b> <b>1/2 Left</b>	<i>Please 'zero' the device in neutral.</i>	<b>1/2 Left</b> <b>3.1</b>	<i>Return to neutral &amp; then repeat</i>	<b>1/2 Left</b> <b>3.2</b>
		degrees		degrees

# Location of apex (point 8) e.g. T4

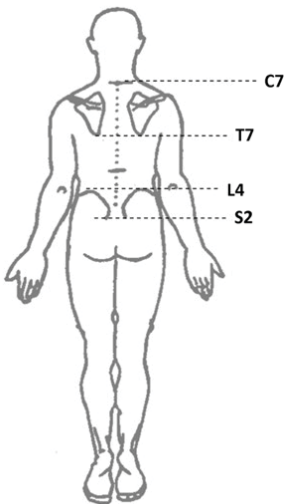
to indicate which part of the spine the localisation & 2 point discrimination tests occur



**Remember to mark the points on the back prior to testing in sections 7 & 8.**

**See the Skin marking protocol in the manual for full details.**

- The apex is defined as the most lateral vertebra of the curve.
- Identify the spinal level that corresponds to this point from the x-ray/ imaging study.
- Using whichever landmark is easiest from the list below, count up or down to find this point.
- Remember, there are 5 Lumbar, 12 thoracic & 7 cervical vertebrae.



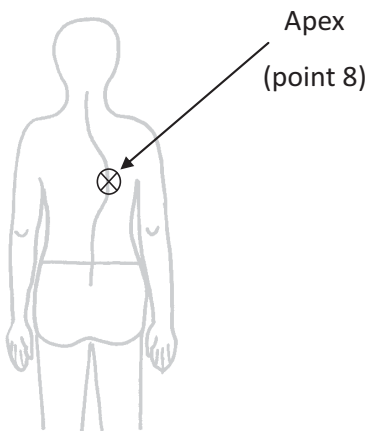
**C7** = most prominent point at base of neck (doesn't disappear on extension).

**T7** = at same level as bottom point of scapulae

**L4** = at same level (or just above) as line between both iliac crests.

**S2** = same level as the PSIS (dimples either side of base of spine)

- Once identified, mark out the testing points using the template.



## **Section 7: Two point discrimination**

### **Equipment:**

Two-point discriminator tool

### **Set up:**

- 1) Patient lying face down on plinth with face looking through face hole. Place flat pillow under stomach.
- 2) Patient's back marked up as previously described using template.

### **Procedure:**

- 1) Show the patient the discriminator tool and give instructions as to what you will be asking them to do (i.e. guess whether they are being touched by one or two points).
- 2) Do a practice by touching them randomly with one or two points on any part of the arm or leg. Apply pressure until the very first blanching of the skin for one second - repeat 3 times. Ensure that both points are contacting skin at the same time (**NB: the patient is to tell you if they feel two points because the points touched at different times**). Ask the patient to guess by saying 'one' or 'two' depending on their perception. If they are unsure, you can repeat the procedure once.
- 3) For actual test, two point discrimination will be conducted at 2 different sites (points 7 & 9). The testing order of sites is provided on the result sheet of this form. Test the first site completely and then test the other site. Testing will take place in 5 mm increments between 10mm and 100mm. The actual order of testing for each distance is randomised (see result sheet).
- 5) **Trial 1:** Ensure the tool is held parallel to the spine. Test each distance at first site in the order given on the result sheet. Record '1' or '2' in the box underneath for Trial 1. As you look along the row of results for Trial 1, there should be a pattern of 1s at the beginning of the sequence, 2's at the end of the sequence, and possibly a mix of 1's and 2s in the middle.

Trial 1	1	1	1	1	1	1	1	2	1	2	1	1	2	2	1	2	2	2	2	2	2	2	2
---------	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

**Trial 2:** Re-measure the values between the last two consecutive 1s and the first 2 consecutive 2s inclusive (see example above). Start at the lower end and work up.

**Trial 3:** Repeat same measures as Trial 2 (see example below) but start at the upper end and work down.

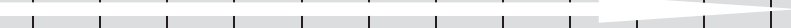
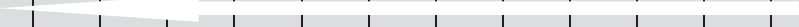
Trial 1	1	1	1	1	1	1	1	2	1	2	1	1	2	2	1	2	2	2	2	2	2	2	2
Trial 2						1	2	2	2	1	1	2	1	2	1	1	2						
Trial 3						2	1	1	2	2	2	2	1	1	2	2	2						

### **Instructions:**

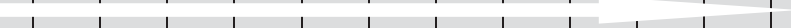
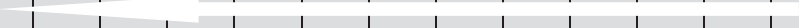
"I am going to tap you on your back 3 times with either one or two points on this device. I want you to tell me whether it is one or two points. I will repeat this many times. If you are not sure I can repeat it."

"I am going to start - please say 'one' when you feel one point and 'two' if you feel two points."

**site 9**

test order	2	5	10	19	20	15	7	14	9	23	11	22	12	17	13	21	6	18	3	16	1	4	8
distance	10mm	15mm	20mm	25mm	30mm	35mm	40mm	45mm	50mm	55mm	60mm	65mm	70mm	75mm	80mm	85mm	90mm	95mm	100mm	100mm	100mm	1 point	1 point
trial 1																							
trial 2																							
trial 3																							

**site 7**

test order	17	12	22	23	13	8	11	5	6	7	10	20	14	16	19	3	4	21	9	15	2	18	1
distance	10mm	15mm	20mm	25mm	30mm	35mm	40mm	45mm	50mm	55mm	60mm	65mm	70mm	75mm	80mm	85mm	90mm	95mm	100mm	100mm	100mm	1 point	1 point
trial 1																							
trial 2																							
trial 3																							

## **Section 8: Localisation**

### **Equipment:**

Monofilament 10g

Chart showing skin markings 1-15 (use chart appropriate to location of curve apex)

### **Set up:**

- 1) Patient lying face down on plinth with face looking through face hole. Place flat pillow under stomach.
- 2) Patient's back marked up as previously described with 15 testing locations.

### **Procedure:**

- 1) Show the patient the chart and give instructions as to what you will be asking them to do (i.e. guess which site has been touched). Leave the chart so they can see it throughout test.
- 2) As a test, touch each site in turn (1-15) and identify them to the patient. Apply pressure until the wire bends for one second. Repeat 3 times in a row.
- 3) For actual test, each site will be tested twice in random order. The testing order of sites are provided on the result sheet of this form (see next page).

### **Measurement:**

Ask the patient to guess the location - record reported location in box under actual location.

---

site	12	7	3	13	15	5	8	1	14	11	2	10	9	4	6
Patient says	12	6	3	14	15	5	8	2	14	12	2	11	9	4	5

---

### **Instructions:**

"Look at the chart with all the numbers on it. I am going to tap you 3 times on your back in these different places and I want you to try and guess which number it is. Each place will be touched more than once. You have only one chance to guess each time - if you are not sure, say the number you think is closest to the place where you feel the touch."

"I am going to start now - please tell me which location you think they are by saying the number from the sheet in front of you."




---

Location

---

<b>14</b>	<b>11</b>	<b>8</b>	<b>7</b>	<b>15</b>	<b>5</b>	<b>10</b>	<b>1</b>	<b>2</b>	<b>12</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>9</b>	<b>13</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>3</b>	<b>11</b>	<b>7</b>	<b>12</b>	<b>5</b>	<b>15</b>	<b>8</b>	<b>9</b>	<b>1</b>	<b>2</b>	<b>14</b>	<b>13</b>	<b>6</b>	<b>10</b>	<b>4</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

---

### Family History


1) Do any other members of the participant's family have scoliosis (i.e. formally diagnosed by a consultant)?

- <sub>1</sub> No
- <sub>2</sub> Yes

If yes, who? (list all that apply) .....

### Research Clinician to answer:

1) Which type of treatment was received by the participant? (please tick)

- <sub>1</sub> Don't know  go to question 2
- <sub>2</sub> Physiotherapy Education & Advice only (control)
- <sub>3</sub> Scoliosis-specific exercise programme (experimental)

Give reasons for your answer (please circle)

Patient said <sub>1</sub>      Patient implied <sub>2</sub>      Change in participants condition <sub>3</sub>

Other: <sub>4</sub> .....

2) If you don't know, which type of treatment do you think they received? (please tick)

- <sub>1</sub> Physiotherapy Education & Advice only (control)
- <sub>2</sub> Scoliosis-specific exercise programme (experimental)

Time that you finished this assessment (24 hour clock):

H	H	M	M



**Please check that all sections have been completed.**

**Please include a copy of the ISIS scan report when you send this back to the ACTIvATeS centre office.**

**Please ensure that you have entered the participant's ID number on the front cover of this questionnaire.**

Thank you very much for your time.