Dear Patient,

We have been conducting research for many years in order to improve the quality of patient care and to make a difference is patient's lives. Along with this letter are questionnaires that may be a bit time-consuming (about 15 minutes) but we feel this is the only way to document your progress. Please know your participation in the research is voluntary and your information that identifies you will only be shared by me and my research team. We do sincerely hope that you will fill out these questionnaires and allow us to collect and analyze your data to be used for lectures and publication in scientific journals.

If you have any questions or concerns about completing the questionnaire please contact my study coordinator Lacey Feldman at 310-855-0751 ext. 2109.

Sincerely yours,

Carl Lauryssen, M.D.

LUMBAR EVALUATION - VISUAL ANALOG SCALE (VAS)		
Patient name:	Date: Month / Day / Year	
Surgery (post-operative):	Birth Date: Month / Day / Year	
Follow-Up Visit: : ☐ Pre-op ☐ 3 Week ☐ 6 Week ☐	3 Month ☐ 6 Month ☐ 12 Month ☐ 24 Month	
Directions: Indicate the severity of your pain by marking a vertical line on each scale below which best describes your level of pain today ranging from "no pain" to "worst possible."		
Pain Scales:		
Back Pain No Pain	Worst Possible	
Right Leg Pain No Pain	Worst Possible	
Left Leg Pain		
	Worst Possible	
No Pain	Worst Possible	

OSWESTRY DISABILITY INDEX QUESTIONNAIRE		
Patient name:	Date: Day / Year	
Follow-Up Visit: : ☐ Pre-op ☐ 3 Week ☐ 6 Week ☐ 3 Mo	onth 🗆 6 Month 🗆 12 Month 🗆 24 Month	
Directions: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. <i>Please answer every section and mark only ONE box for each question.</i> We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.		
Questions:		
1. Pain Intensity □₀ I have no pain at the moment. □₁ The pain is very mild at the moment. □₂ The pain is moderate at the moment. □₃ The pain is fairly severe at the moment. □₄ The pain is very severe at the moment. □₄ The pain is the worst imaginable at the moment.	 6. Standing □₀ I can stand as long as I want without extra pain. □₁ I can stand as long as I want, but it gives me extra pain. □₂ Pain prevents me from standing for more than 1 hour. □₃ Pain prevents me from standing for more than ½ hour. □₄ Pain prevents me from standing for more than 10 min. minutes. □₅ Pain prevents me from standing at all. 	
2. Personal Care (Washing, Dressing, etc.) □ I can look after my self normally without causing extra pain □ I can look after myself normally, but it is very painful. □ It is painful to look after myself, and I am slow and careful. □ I need some help, but can manage most of my personal care. □ I need help every day in most aspects of self-care.	7. Sleeping □₀ My sleep is never disturbed by pain. □₁ My sleep is occasionally disturbed by pain. □₂ Because of pain, I have less than 6 hours of sleep. □₃ Because of pain, I have less than 4 hours of sleep. □₄ Because of pain, I have less than 2 hours of sleep. □₅ Pain prevents me from sleeping at all.	
3. Lifting □₀ I can lift heavy weights with out extra pain. □₁ I can left heavy weights but it gives extra pain. □₂ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. a table. □₃ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. □₄ I can lift only very light weights. □₅ I cannot lift or carry anything at all. 4. Walking □₀ Pain does not prevent me from walking any distance. □₁ Pain prevents me from walking more than 1 mile. □₂ Pain prevents me from walking more than 1/4 mile.	8. Sex Life (if applicable) □₀ My sex life is normal and causes no extra pain □₁ My sex life is normal but causes some extra pain. □₂ My sex life is nearly normal but is very painful. □₃ My sex life is severely restricted by pain. □₄ My sex life is nearly absent because of pain. □₅ Pain prevents any sex life at all. 9. Social Life □₀ My social life is normal and causes me no extra pain. □₁ My social life is normal but increases the degree of pain. □₂ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc. □₃ Pain has restricted my social life and I do not go out as often. □₄ Pain has restricted my social life to my home. □₅ I have no social life because of pain.	
 □₃ Pain prevents me from walking more than 100 yards. □₄ I can only walk using a stick or crutches. □₅ I am in bed most of the time and have to crawl to the toilet. 5. Sitting □₀ I can sit in any chair as long as I like. □₁ I can sit in my favorite chair as long as I like. □₂ Pain prevents me from sitting for more than 1 hour. □₃ Pain prevents me from sitting for more than ½ hour. □₄ Pain prevents me from sitting for more than 10 minutes. □₅ Pain prevents me from sitting at all. 	10. Traveling □₀ I can travel anywhere without pain. □₁ I can travel anywhere but it gives extra pain. □₂ Pain is bad but I manage journeys over two hours. □₃ Pain restricts me to journeys of less than one hour. □₄ Pain restricts me to short necessary journeys under 30 minutes. □₅ Pain prevents me from traveling except to receive treatment.	

ZURICH CLAUDICATION QUESTIONNAIRE		
Patient name:	Date: Day / Year	
Follow-Up Visit: : Pre-op 3 Week 6 Week 3 Month 6 Month 12 Month 24 Month		
Directions: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. <i>Please answer every section and mark only ONE box for each question.</i> We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.		
In the last month, how would you describe:		
 The pain you have had on average including pain in your back, buttocks and pain that goes down the legs? □₁ None □₂ Mild □₃ Moderate □₄ Severe □₅ Very Severe 	 7. Problems with your balance? □₁ No, I've had no problems with balance □₃ Yes, sometimes I feel my balance is off, or that I am not sure footed □₅ Yes, often I feel my balance is off, or that I am not sure footed In the last month, on a typical day: 	
2. How often have you had back, buttock, or leg pain? □1 Less than once a week □2 At least once a week □3 Everyday, for at least a few minutes □4 Everyday, for most of the day □5 Every minute of the day 3. The pain in your back or buttocks? □1 None □2 Mild □3 Moderate □4 Severe □5 Very Severe 4. The pain in your legs or feet? □1 None □2 Mild □3 Moderate □4 Severe □5 Very Severe	 8. How far have you been able to walk? □¹ Over 2 miles □² Over 2 blocks, but less than 2 miles □³ Over 50 feet, but less than 2 blocks □⁴ Less than 50 feet 9. Have you taken walks outdoors or in malls for pleasure? □¹ Yes, comfortably □² Yes, but sometimes with pain □³ Yes, but always with pain □⁴ No 10. Have you been shopping for groceries or other items? □¹ Yes, comfortably □² Yes, but sometimes with pain □³ Yes, but sometimes with pain □³ Yes, but always with pain □³ Yes, but always with pain □³ No 11. Have you walked around the different rooms in your house or apartment? 	
5. Numbness or tingling in your legs or feet? □1 None □2 Mild □3 Moderate □4 Severe □5 Very Severe 6. Weakness in your legs or feet? □1 None □2 Mild □3 Moderate □4 Severe	your nouse or apartment? □1 Yes, comfortably □2 Yes, but sometimes with pain □3 Yes, but always with pain □4 No 12. Have you walked from your bedroom to the bathroom? □1 Yes, comfortably □2 Yes, but sometimes with pain □3 Yes, but always with pain □4 No	

SF-12 PATIENT QUESTIONNAIRE		
Patient name:	Date: Day / Year	
Follow-Up Visit: : Pre-op 3 Week 6 Week 3 Month 6 Month 12 Month 24 Month		
This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the box in front of the question. <i>Please answer every section and mark only ONE box for each question.</i> If you are unsure about how to answer a question, please give the best answer you can.		
Questions:	8. During the PAST 4 WEEKS, how much did PAIN	
 In general, would you say your health is: □₁ Excellent □₂ Very Good □₃ Good □₄ Fair □₅ Poor 	interfere with your normal work (including both work outside the home and the housework)? □₁ Not At All □₂ A Little Bit □₃ Moderately □₄ Quite a Bit □₅ Extremely	
The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?	The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. How much of the time during the PAST 4 WEEKS -	
 2. MODERATE ACTIVITES, such as moving a table, bowling, playing golf, etc: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	9. Have you felt calm and peaceful? □₁ All of the Time □₂ Most of the Time □₃ A Good Bit of the Time □₄ Some of the Time □₅ A Little of the Time □₀ None of the Time	
☐2 Yes, Limited A Little ☐3 No, Not Limited At All During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A REWSULT OF YOUR PHYSICAL HEALTH?	10.Did you have a lot of energy? □₁ All of the Time □₂ Most of the Time □₃ A Good Bit of the Time □₄ Some of the Time □₅ A Little of the Time	
4. ACCOMPLISHED LESS than you would like: □1 Yes □2 No	☐ ₆ None of the Time 11.Have you felt downhearted and blue?	
Were limited in the KIND of work or other activities: □ Yes □ No	 □₁ All of the Time □₂ Most of the Time □₃ A Good Bit of the Time □₄ Some of the Time □₅ A Little of the Time 	
During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?	 □₆ None of the Time 12. Has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting friends, relatives, etc.)? 	
6. ACCOMPLISHED LESS than you would like: □1 Yes □2 No 7. Didn't do work or other activities as CAREELILLY	 □₁ All of the Time □₂ Most of the Time □₃ A Good Bit of the Time 	
 7. Didn't do work or other activities as CAREFULLY as usual: □₁ Yes □₂ No 	\square_4 Some of the Time \square_5 A Little of the Time \square_6 None of the Time	