AO SPINE | Knowledge Forum Tumor

Spine Oncology Study Group Outcomes Questionnaire 2.0

(SOSGOQ2.0)

Directions: This set of questions asks for how you view your health status. Please think about your level of functioning and symptoms over the past 4 weeks while filling out this questionnaire. It is important that you answer each of the questions **YOURSELF**. Mark **ONLY ONE ANSWER** for each question. Questions 21-27 should only be completed **AFTER** your treatment, at follow-up visits.

Patient Name: ______________________

Date (MM/DD/YY): _____ / _____ / _____

Patient ID: ______________________

(to be filled in by the health professional)

To be completed by the PATIENT

1. What is your level of activity?
- ☐ Full activities without restriction
- ☐ Moderate activities out of house
- ☐ Mobility limited to within house
- ☐ Bed to chair activity
- ☐ Bedridden

2. What is your ability to work (including at home)/study?
- ☐ Unlimited
- ☐ 4-8 hours per day
- ☐ 2-4 hours per day
- ☐ Less than 2 hours per day
- ☐ Not at all

3. Does your spine limit your ability to care for yourself?
- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

4. Do you require assistance from others to travel outside the home?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

5. What assistance do you need with your walking?
- ☐ None
- ☐ A cane
- ☐ A walker/2 canes
- ☐ Assistance from others
- ☐ Cannot walk at all

6. Do you leave the house for social functions?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

7. Do you have weakness in your legs?
- ☐ None
- ☐ Mild occasionally
- ☐ Mild constantly
- ☐ Moderate constantly
- ☐ Severe constantly

8. Do you have weakness in your arms?
- ☐ None
- ☐ Mild occasionally
- ☐ Mild constantly
- ☐ Moderate constantly
- ☐ Severe constantly

9. Do you have difficulty controlling your bowel function beyond episodes of diarrhea/constipation?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

10. Do you have difficulty controlling your bladder function?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Requires catheterization

11. Overall, on average, how much back/neck pain do you have?
- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe

12. When you are in your most comfortable position, do you still experience back/neck pain (limiting your sleep)?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

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Source: Cancer, 2018 Apr 15;124(8):1828-1838. Versteeg et al. Psychometric evaluation and adaptation of the Spine Oncology Study Group Outcomes Questionnaire to evaluate health-related quality of life in patients with spinal metastases.

13. **How much has your pain limited your mobility (sitting, standing, walking)?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Constantly

14. **How confident do you feel in your ability to manage your pain on your own?**
- ☐ Not confident at all
- ☐ Minimally confident
- ☐ Moderately confident
- ☐ Mostly confident
- ☐ Completely confident

15. **When I feel pain, it is awful and I feel that it overwhelms me**.
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

16. **Have you felt depressed?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

17. **Do you feel anxiety about your health related to your spine?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

18. **Does your spine influence your ability to concentrate on conversations, reading, and television?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

19. **Do you feel that your spine condition affects your personal relationships?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

20. **Are you comfortable meeting new people?**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

Complete only AFTER your treatment

21. **Are you satisfied with the results of your spine tumor management?**
- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

22. **Would you choose the same management of your spine tumor again?**
- ☐ Definitely yes
- ☐ Probably yes
- ☐ Not sure
- ☐ Probably not
- ☐ Definitely not

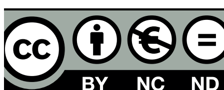
23. **How has treatment of your spine changed your physical function and ability to pursue activities of daily living?**
- ☐ Much better
- ☐ Somewhat better
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse

24. **How has treatment of your spine affected your spinal cord and/or nerve function?**
- ☐ Much better
- ☐ Somewhat better
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse

25. **How has your treatment affected your overall pain from your spine?**
- ☐ Much better
- ☐ Somewhat better
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse

26. **How has treatment of your spine changed your depression and anxiety?**
- ☐ Much better
- ☐ Somewhat better
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse

27. **How has treatment of your spine changed your ability to function socially?**
- ☐ Much better
- ☐ Somewhat better
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse



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