



SOCIODEMOGRAPHICS PLUS

Final RHSCIR

INTERVIEW

SP-FinalRHSCIR

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Sociodemographics Plus- Final RHSCIR

☐ Information unavailable, unable to complete.

Specify Reason: _____

Instructions: Ask the participant the following questions.

1. What, if any, compensation are you receiving as a result of your spinal cord injury? (check ALL that apply)

- ☐ Worker's insurance (e.g., Worker's Compensation Board (WCB) or similar)
- ☐ Other disability insurance (e.g., Federal CPP Disability, Provincial Persons with Disability (PWD), private short or long term disability)
- ☐ Vehicle insurance (government or private)
- ☐ Other insurance (i.e., Employment Insurance, private insurance including payment protection plans, life insurance, accidental death and dismemberment, Veterans Benefits or Veterans Affairs Canada Benefits)
- ☐ Other compensation (specify): _____
- ☐ Unknown compensation type
- ☐ None

2. What is your current body weight? (if the individual is unsure of the appropriate response, check with a member of the individual's health care team)

Round up to
the nearest
whole
number.

☐ lbs

☐ kg

☐ Unknown

3. Since your injury, have you used cannabis/marijuana for MEDICAL reasons?

(This includes use for any medical purpose even if not prescribed by a physician)

- ☐ Yes
- ☐ No
- ☐ Unknown

4. a) Since your injury, have you used prescribed medications, street drugs or cannabis/marijuana for NON-MEDICAL reasons?

- ☐ Yes
- ☐ No
- ☐ Unknown

Sociodemographics Plus - continued**b) If Yes, check ALL that apply:**

- ☐ Cocaine
- ☐ Cannabis/marijuana
- ☐ Hallucinogens
- ☐ Heroin
- ☐ Opiates
- ☐ Speed/stimulants
- ☐ Medications prescribed for you
- ☐ Medications prescribed for someone else
- ☐ Other or unknown type

5. Upon discharge, if you are not going to be living in a nursing home, hospital or correctional institute:**a) Who will you be living with?** (choose ALL that apply)

- ☐ Partner/spouse
- ☐ Family member
- ☐ Non-family, unpaid (e.g., roommate)
- ☐ Paid attendant
- ☐ Alone
- ☐ Other (specify): _____
- ☐ N/A – I will be living in a nursing home, hospital or correctional institute

b) Will you be receiving health services at home? (e.g., homecare/support, home OT, etc.)

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ N/A – I will be living in a nursing home, hospital or correctional institute

6. a) Do you have a regular health care provider? By this, we mean one health professional that you regularly see or talk to when you need care or advice for your health.

- ☐ Yes
- ☐ No
- ☐ Unknown

b) Is that regular health care provider a...?

- ☐ Family doctor or general practitioner
- ☐ Medical specialist such as a cardiologist or a pediatrician
- ☐ Nurse practitioner
- ☐ Other (specify): _____
- ☐ Unknown

Sociodemographics Plus - continued

- 7. a) Do you use any type of ventilatory assistance including (but not limited to) a mechanical ventilator, phrenic nerve stimulator, diaphragmatic pacer, external negative pressure device or Bi-Level Positive Airway Pressure (BIPAP®)?** (this does not include routine administration of oxygen, intermittent positive pressure breathing (IPPB), or continuous positive airway pressure (CPAP))

- ☐ Yes, 24 hours per day at discharge (this includes if you are weaning from ventilator)
- ☐ Yes, less than 24 hrs per day at discharge
- ☐ Yes, unknown number of hours per day at discharge
- ☐ No (skip to Question 8)

- b) If Yes, please indicate type and complete additional information** (please collect this information from participant's medical record, if required)

- ☐ Non-Invasive Ventilation with Bi-Level Positive Airway Pressure (BIPAP®)
- ☐ Non-Invasive Ventilation with ventilator (e.g., Trilogy, Stellar, etc.)
- ☐ Tracheostomy Ventilation
- ☐ Diaphragmatic Pacing
- ☐ Phrenic Nerve Stimulation
- ☐ Other (specify): _____

Penn Spasticity Scale

- 8. Do you ever have muscle spasms?** (muscle spasms are uncontrolled tightening or contracting and then releasing of muscles [this may cause unintended movement of your body])

- ☐ Yes
- ☐ No (skip to Pain questionnaire)
- ☐ Unknown

- 9. Which best describes your spasms?**

- ☐ Induced only by stimulation (e.g., when a muscle is stretched, or there is a painful stimulus below the level of injury, etc.)
- ☐ Infrequent spontaneous spasms occurring < 1 per hr
- ☐ Spontaneous spasms occurring < 10 per hr
- ☐ Spontaneous spasms occurring > 10 per hr
- ☐ Unknown

Pain Questionnaire

These questions ask your opinion about any pain you may be experiencing and how it may interfere with your daily living. Also, you will be asked to describe what you do to manage it.

10. a) Are you currently using or receiving any treatment for a pain problem?

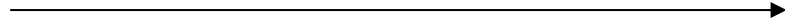
- ☐ Yes (e.g., medications, recreational drugs, physical therapies, psychological treatment, etc.)
- ☐ No
- ☐ Unknown

b) If Yes, What treatments do you use to manage your pain? (check ALL that apply)

- ☐ Complementary (e.g., biofeedback, acupuncture, hypnosis)
- ☐ Medical and procedural or neuromodulation (e.g., nerve blocks, injections, implanted stimulators, intrathecal pump, TENS)
- ☐ Non-prescription medications (e.g., non-prescription pain killers such as Tylenol®)
- ☐ Non-traditional (e.g., naturopathy, homeopathy, herbal remedies)
- ☐ Psychotherapeutic (e.g., psychotherapy, cognitive behavioural therapy, relaxation, stress management, psycho-education, support group)
- ☐ Physical therapies (e.g., physiotherapy, massage, chiropractic)
- ☐ Recreational drugs (e.g., marijuana)
- ☐ Prescription medications (e.g., morphine, codeine)
- ☐ Other (specify): _____

11. Overall, how satisfied are you with the management of your pain?

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

Not at all satisfied  Completely satisfied


12. a) Have you had any pain during the last 7 days, including today?

- ☐ Yes
- ☐ No (skip to question 13)

b) If YES, in the LAST WEEK:


i) In general, how much has pain interfered with your day to day activities in the last week?

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown


No interference  Extreme interference

ii) In general, how much has pain interfered with your overall mood in the past week?

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

No interference  Extreme interference

iii) In general, how much has pain interfered with your ability to get a good night's sleep?

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown
No interference  Extreme interference

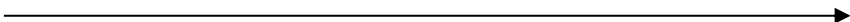
13. Since your injury, have you experienced neuropathic pain? (pain that is often ongoing and intense that occurs spontaneously or by light touching and is characterized by feelings of burning, shooting, tingling, etc.)

- ☐ Yes
☐ No (skip to Data Collection Details)

14. Location(s) of your neuropathic pain (check ALL that apply):

- ☐ Head
☐ Neck and/or shoulders
☐ Arms and/or hands
☐ Torso (chest, abdomen, pelvis, and/or genitals)
☐ Back (upper and/or lower back)
☐ Hips, buttocks, and/or anus
☐ Upper legs/thighs
☐ Lower legs or feet

15. a) Average pain intensity of your neuropathic pain in the past week:

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown
No pain  Pain as bad as you can imagine

b) Have you received some form of treatment for the neuropathic pain?

- ☐ Yes
☐ No
☐ Unknown

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c) When you had this, did it limit your activities?☐ Yes☐ No

Data Collection Details

Interviewer Name: (please print)		Initial Here:		Date Interview Completed:	YYYY-MM-DD
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