

# **OUTCOME MEASUREMENT TOOLS**

**for**

## **MASSAGE THERAPY**

1. Oswestry Disability Low Back Pain Questionnaire (*Revised*)
2. Neck Disability Index
3. Headache Disability Inventory
4. Pre- and Post-Treatment Visual Analogue Scale (VAS)
5. Quadruple Visual Analogue Scale (VAS)
6. Health Status Questionnaire (HSQ-12)
7. General Satisfaction Survey

**January 2006**  
**Version 6.0**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

**OSWESTRY DISABILITY INDEX 2.0**

**PLEASE READ:** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A I have no pain at the moment.          B The pain is very mild at the moment.          C The pain is moderate at the moment.          D The pain is fairly severe at the moment.          E The pain is very severe at the moment.          F The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Standing</i></p> <p>A I can stand as long as I want without extra pain.          B I can stand as long as I want but it gives me extra pain.          C Pain prevents me from standing for more than 1 hour.          D Pain prevents me from standing for more than 1/2 hour.          E Pain prevents me from standing for more than 10 minutes.          F Pain prevents me from standing at all.</p>
<p><i>SECTION 2 - Personal Care (washing, dressing, etc.)</i></p> <p>A I can look after myself normally without causing extra pain.          B I can look after myself normally but it is very painful.          C It is painful to look after myself and I am slow and careful.          D I need some help but manage most of my personal care.          E I need help every day in most aspects of self care.          F I do not get dressed, wash with difficulty <input type="checkbox"/> and stay in bed.</p>	<p><i>SECTION 7 - Sleeping</i></p> <p>A My sleep is never disturbed by pain.          B My sleep is occasionally disturbed by pain.          C Because of pain I have less than 6 hours' sleep.          D Because of pain I have less than 4 hours' sleep.          E Because of pain I have less than 2 hours' sleep.          F Pain prevents me from sleeping at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain.          B I can lift heavy weights, but it causes extra pain.          C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.          D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.          E I can only lift very light weights, at the most.          F I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Sex Life (if applicable)</i></p> <p>A My sex life is normal and causes me no extra pain.          B My sex life is normal, but causes some extra pain.          C My sex life is nearly normal but is very painful.          D My sex life is severely restricted by pain.          E My sex life is nearly absent because of pain.          F Pain prevents any sex life at all.</p>
<p><i>SECTION 4 - Walking</i></p> <p>A Pain does not prevent me from walking any distance.          B Pain prevents me from walking more than one mile.          C Pain prevents me from walking more than 1/4 mile.          D Pain prevents me from walking more than 100 yards.          E I can only walk while using a stick or crutches.          F I am in bed most of the time and have to crawl to the toilet.</p>	<p><i>SECTION 9 - Social Life</i></p> <p>A My social life is normal and causes me no extra pain.          B My social life is normal, but increases the degree of pain.          C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.          D Pain has restricted my social life and I do not go out as often.          E Pain has restricted my social life to my home.          F I have no social life because of the pain.</p>
<p><i>SECTION 5 - Sitting</i></p> <p>A I can sit in any chair as long as I like.          B I can only sit in my favorite chair as long as I like.          C Pain prevents me from sitting more than 1 hour.          D Pain prevents me from sitting more than 1/2 hour.          E Pain prevents me from sitting more than ten minutes.          F Pain prevents me from sitting at all.</p>	<p><i>SECTION 10 - Traveling</i></p> <p>A I can travel anywhere without pain.          B I can travel anywhere but I gives extra pain.          C Pain is bad but I manage journeys over 2 hours.          D Pain restricts me to journeys of less than 1 hour.          E Pain restricts me to short necessary journeys under 30 minutes.          F Pain prevents me from traveling except to receive treatment.</p>

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SCORING METHOD FOR THE OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

- Each of the 10 sections is scored separately (0 to 5 points each) and then added up (max. total = 50).

*EXAMPLE:*

Section 1. Pain Intensity	Point Value
A. ____ I have no pain at the moment	0
B. ____ The pain is very mild at the moment	1
C. ____ The pain is moderate at the moment	2
D. ____ The pain is fairly severe at the moment	3
E. ____ The pain is very severe at the moment	4
F. ____ The pain is the worst imaginable	5

- If all 10 sections are completed, simply double the patients score.
- If a section is omitted, divide the patient's total score by the number of sections completed times 5.

*FORMULA:* 
$$\frac{\text{PATIENT'S SCORE}}{\# \text{ OF SECTIONS COMPLETED}} \times 5 \times 100 = \text{ \% DISABILITY}$$

*EXAMPLE:*

If 9 of 10 sections are completed, divide the patient's score by 9 X 5 = 45; if

Patient's Score: 22

Number of sections completed: 9 (9 X 5 = 45)

$22/45 \times 100 = 48 \%$  disability

- Interpretation of disability scores (from original article):

SCORE	INTERPRETATION OF THE OSWESTRY LBP DISABILITY QUESTIONNAIRE
0-20% Minimal Disability	Can cope w/ most ADL's. Usually no treatment needed, apart from advice on lifting, sitting, posture, physical fitness and diet. In this group, some patients have particular difficulty with sitting and this may be important if their occupation is sedentary (typist, driver, etc.)
20-40% Moderate Disability	This group experiences more pain and problems with sitting, lifting and standing. Travel and social life are more difficult and they may well be off work. Personal care, sexual activity and sleeping are not grossly affected, and the back condition can usually be managed by conservative means.
40-60% Severe Disability	Pain remains the main problem in this group of patients by travel, personal care, social life, sexual activity and sleep are also affected. These patients require detailed investigation.
60-80% Crippled	Back pain impinges on all aspects of these patients' lives both at home and at work. <i>Positive intervention is required.</i>
80-100%	These patients are either bed-bound or exaggerating their symptoms. This can be evaluated by careful observation of the patient during the medical examination.

Reference: Fairbank JCT, Davies JB, Couper J, O'Brien JP (1980) The Oswestry low back pain disability questionnaire. *Physiother* 66:271-273

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

### NECK DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A. I have no pain at the moment.          B. The pain is very mild at the moment.          C. The pain is moderate at the moment.          D. The pain is fairly severe at the moment.          E. The pain is very severe at the moment.          F. The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration/</i></p> <p>A. I can concentrate fully when I want to with no difficulty.          B. I can concentrate fully when I want to with slight difficulty.          C. I have a fair degree of difficulty in concentrating when I want to.          D. I have a lot of difficulty in concentrating when I want to.          E. I have a great deal of difficulty in concentrating when I want to.          F. I cannot concentrate at all.</p>
<p><i>SECTION 2 -Personal Care (Washing, Dressing, etc.)</i></p> <p>A. I can look after myself normally without causing extra pain.          B. I can look after myself normally, but it causes extra pain.          C. It is painful to look after myself and I am slow and careful.          D. I need some help, but manage most of my personal care.          E. I need help every day in most aspects of self care.          F. I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p>A. I can do as much work as I want to.          B. I can only do my usual work, but no more.          C. I can do most of my usual work, but no more.          D. I cannot do my usual work.          E. I can hardly do any work at all.          F. I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A. I can lift heavy weights without extra pain.          B. I can lift heavy weights, but it gives extra pain.          C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.          D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.          E. I can lift very light weights.          F. I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 – Driving</i></p> <p>A. I can drive my car without any neck pain.          B. I can drive my car as long as I want with slight pain in my neck.          C. I can drive my car as long as I want with moderate pain in my neck.          D. I cannot drive my car as long as I want because of moderate pain in my neck.          E. I can hardly drive at all because of severe pain in my neck.          F. I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A. I can read as much as I want to with no pain in my neck.          B. I can read as much as I want to with slight pain in my neck.          C. I can read as much as I want to with moderate pain in my neck.          D. I cannot read as much as I want because of moderate pain in my neck.          E. I cannot read as much as I want because of severe pain in my neck.          F. I cannot read at all.</p>	<p><i>SECTION 9 – Sleeping</i></p> <p>A. I have no trouble sleeping.          B. My sleep is slightly disturbed (less than 1 hour sleepless).          C. My sleep is mildly disturbed (1-2 hours sleepless).          D. My sleep is moderately disturbed (2-3 hours sleepless).          E. My sleep is greatly disturbed (3-5 hours sleepless).          F. My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 – Headaches</i></p> <p>A. I have no headaches at all.          B. I have slight headaches which come infrequently.          C. I have moderate headaches which come infrequently.          D. I have moderate headaches which come frequently.          E. I have severe headaches which come frequently.          F. I have headaches almost all the time.</p>	<p><i>SECTION 10 – Recreation</i></p> <p>A. I am able to engage in all of my recreational activities with no neck pain at all.          B. I am able to engage in all of my recreational activities with some pain in my neck.          C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.          D. I am able to engage in a few of my recreational activities because of pain in my neck.          E. I can hardly do any recreational activities because of pain in my neck.          F. I cannot do any recreational activities at all.</p>

COMMENTS: \_\_\_\_\_



NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ Scores Total: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
 (100) (52) (48)

### HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 1 but less than 4 per month  
 [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES," "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches, I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel that a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SCORING METHOD FOR HEADACHE DISABILITY INVENTORY

*E* = Emotionally based questions (#'s 1, 3, 5, 6, 8, 9, 10, 11, 12, 14, 20, 22, 23)  
13 questions total

*F* = Functionally based questions (#'s 2, 4, 7, 13, 15, 16, 17, 18, 19, 21, 24, 25)  
12 questions total

### SCORE VALUES

“YES” = 4 POINTS  
“SOMETIMES” = 2 POINTS  
“NO” = 0 POINTS

### FINAL SCORES

**EMOTIONAL** = total sum of columns for the “E” questions above / Pt’s total (13X4=52) or,  
**Patients Score (E questions) / Pt total score**

**FUNCTIONAL** = total sum of columns for the “F” questions above / total possible (12X4=48) or,  
**Patients Score (F questions) / Pt total score**

**and/or.....**

**TOTAL COMPOSITE SCORE** = total sum of columns for the “F” questions above / total possible (12X4=48) or,  
**Patients Score (E + F questions) / 100**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ DOI \_\_\_\_\_

## PRE AND POST VISUAL ANALOGUE SCALE

### PRE-TREATMENT VAS

Please place a mark through the line below that most accurately represents the pain level that you are feeling *RIGHT NOW*. Please note that “UNBEARABLE PAIN” is located on the right hand side of the line and “NO PAIN” is located on the left.

No Pain \_\_\_\_\_ Unbearable

**FOLD HERE**-----

### POST-TREATMENT VAS (fold in half when completing post-test VAS)

Please place a mark through the line below that most accurately represents the pain level that you are feeling *RIGHT NOW*. Please note that “UNBEARABLE PAIN” is located on the right hand side of the line and “NO PAIN” is located on the left.

No Pain \_\_\_\_\_ Unbearable



NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

## HEALTH STATUS QUESTIONNAIRE (HSQ-12)

1. In general, would you say your health is: *(Circle one number)*

- Excellent ..... 1
- Very Good..... 2
- Good..... 3
- Fair ..... 4
- Poor ..... 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? *(Circle one number on each line)*

- |   | Yes,<br>limited a<br>lot | Yes,<br>limited a<br>little | No, not<br>limited at<br>all |
|---|--------------------------|-----------------------------|------------------------------|
| 2. Lifting or carrying groceries.....   | 1                        | 2                           | 3                            |
| 3. Climbing several flights of stairs.....  | 1                        | 2                           | 3                            |
| 4. Walking several blocks.....  | 1                        | 2                           | 3                            |
| 5. During the past 4 weeks how much difficulty did you have doing your work or other regular daily activities as a result of your physical health? <i>(Circle one number)</i>   |                          |                             |                              |
| None at all.....  | 1                        |                             |                              |
| A little bit.....   | 2                        |                             |                              |
| Moderately.....   | 3                        |                             |                              |
| Quite a bit.....  | 4                        |                             |                              |
| Couldn't do any work.....   | 5                        |                             |                              |
| 6. During the <b>past 4 weeks</b> , to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)? <i>(circle one number)</i> |                          |                             |                              |
| None at all.....  | 1                        |                             |                              |
| A little bit.....   | 2                        |                             |                              |
| Moderately.....   | 3                        |                             |                              |
| Quite a bit.....  | 4                        |                             |                              |
| Extremely.....  | 5                        |                             |                              |
| 7. During the <b>past 4 weeks</b> , to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? <i>(circle one number)</i>                        |                          |                             |                              |
| None at all.....  | 1                        |                             |                              |
| Slightly.....   | 2                        |                             |                              |
| Moderately.....   | 3                        |                             |                              |
| Quite a bit.....  | 4                        |                             |                              |
| Extremely.....  | 5                        |                             |                              |

8. How much bodily pain have you had during the **past 4 weeks**? (*Circle one number*)

- None ..... 1
- Very Mild..... 2
- Mild..... 3
- Moderate ..... 4
- Severe..... 5
- Very Severe..... 6

These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks... (*Circle one number on each line*)

	<b>All of the time</b>	<b>Most of the time</b>	<b>A good bit of the time</b>	<b>Some of the time</b>	<b>Little of the time</b>	<b>None of the time</b>
9. Have you felt calm and peaceful?	1	2	3	4	5	6
10. Did you have a lot of energy?	1	2	3	4	5	6
11. Have you felt downhearted and blue?	1	2	3	4	5	6
12. Have you been happy?	1	2	3	4	5	6

Please answer YES or NO for each question by circling "1" or "2" on each line.

	<b>Yes</b>	<b>No</b>
13. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	1	2
14. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	1	2
15. Have you felt depressed or sad much of the time in the past year?	1	2

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_  
**DECODED KEY: SEE INFORMATION ON LAST PAGE FOR SCORING**

## HEALTH STATUS QUESTIONNAIRE (HSQ-12)

1. In general, would you say your health is (*Circle one number*):

	<u>Recode</u>
Excellent .....	100
Very Good.....	85
Good.....	60
Fair .....	25
Poor .....	0

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all	
2. Lifting or carrying groceries.....	1	2	3	0, 50, 100
3. Climbing several flights of stairs.....	1	2	3	0, 50, 100
4. Walking several blocks.....	1	2	3	0, 50, 100

5. During the **past 4 weeks** how much difficulty did you have doing your work or other regular daily activities as a result of your physical health? (*circle one number*)

None at all.....	1	100
A little bit .....	2	65
Moderately .....	3	25
Quite a bit.....	4	10
Couldn't do any work .....	5	0

6. During the **past 4 weeks**, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)? (*circle one number*)

None at all.....	1	100
A little bit .....	2	65
Moderately .....	3	45
Quite a bit.....	4	20
Extremely.....	5	0

7. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (*circle one number*)

None at all.....	1	100
Slightly .....	2	75
Moderately .....	3	50
Quite a bit.....	4	25
Extremely.....	5	0

8. How much bodily pain have you had during the **past 4 weeks?** (*Circle one number*)

	<u>Recode</u>
None.....	1 100
Very Mild.....	2 85
Mild.....	3 65
Moderate.....	4 45
Severe.....	5 25
Very Severe.....	6 0

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	<b>All of the time</b>	<b>Most of the time</b>	<b>A good bit of the time</b>	<b>Some of the time</b>	<b>Little of the time</b>	<b>None of the time</b>	
9. Have you felt calm and peaceful?	1	2	3	4	5	6	100, 80, 60, 40, 20, 0
10. Did you have a lot of energy?	1	2	3	4	5	6	100, 80, 60, 40, 20, 0
11. Have you felt downhearted and blue?	1	2	3	4	5	6	0, 20, 40, 60, 80, 100
12. Have you been happy?	1	2	3	4	5	6	100, 80, 60, 40, 20, 0

**TABLE 2: SECOND STEP: HSQ-12 Scoring Algorithms / 2<sup>nd</sup> step: Computing Scale Scores**

<b>SCALE</b>	<b>No. of Items</b>	<b>Scale Items</b>	<b>Minimum No. of Items needed to Compute a Score</b>
Physical Functioning	3	2, 3, 4	2
Role Limitations Attributable to: Physical Health (Role-Physical)	1	5	1
Bodily Pain	1	8	1
Health Perception	1	1	1
Energy / Fatigue	1	10	1
Social Functioning	1	7	1
Role Limitations Attributable to: Mental Health (Role-Mental)	1	6	1
Mental Health	3	9, 11, 12	2

*Ware J Jr, Kosinski M, Keller A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. Med Care. 1996 Mar;34(3):220-33*

## GENERAL SATISFACTION SURVEY

*Over the Course of your treatment, how satisfied were you with your overall care?*

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied