

Table 1 SF-36 scores for adults with CMT and comparative Australian norms, and sub-grouped for gender and age.

Sample (N)	Physical Function	Role Physical	Bodily Pain	General Health	Vitality	Social Function	Role Emotional	Mental Health
Australian Norms (N=18,800)	82.5 (23.9)	79.8 (35.1)	76.8 (25.0)	71.6 (20.3)	64.5 (19.8)	84.9 (22.5)	82.8 (32.3)	75.9 (17.0)
Total CMT sample (N=295)	54.9 (28.4)*	60.5 (41.5)*	64.9 (25.3)*	61.4 (23.5)*	50.5 (21.7)*	76.8 (25.4)*	75.9 (37.5)*	72.3 (18.1)*
Gender								
- Men (N=124)	54.6 (29.2)	59.6 (40.6)	65.0 (27.7)	60.2 (24.1)	51.5 (21.3)	76.0 (27.6)	75.1 (38.3)	72.2 (19.1)
- Women (N=171)	55.1 (27.9)	61.2 (42.3)	64.9 (23.5)	62.2 (23.1)	49.7 (22.0)	77.4 (23.8)	76.6 (36.9)	72.3 (17.4)
Age								
- 18 to 24 years (N=22)	59.8 (27.7)	65.9 (39.0)	65.9 (21.1)	67.3 (22.1)	52.5 (16.4)	79.5 (20.2)	77.3 (36.2)	68.5 (18.4)
- 25 to 34 years (N=46)	69.5 (24.9)	71.7 (36.7)	68.0 (22.8)	63.2 (25.2)	52.9 (21.3)	79.5 (24.0)	76.8 (37.1)	69.6 (19.4)
- 35 to 44 years (N=51)	58.4 (25.0)	66.2 (40.8)	64.3 (25.2)	60.9 (21.2)	51.4 (20.4)	79.2 (23.3)	81.7 (34.2)	73.0 (15.7)
- 45 to 54 years (N=54)	62.3 (26.6)	67.1 (42.6)	66.0 (25.1)	61.0 (23.3)	52.2 (24.1)	78.0 (25.6)	77.8 (36.6)	71.6 (17.4)
- 55 to 64 years (N=60)	45.2 (26.5) [#]	56.7 (39.8)	65.1 (27.4)	61.3 (25.8)	46.6 (24.0)	77.5 (25.6)	76.7 (37.0)	74.5 (19.2)
- 65 to 74 years (N=43)	51.4 (28.0) [*]	47.7 (42.9)	64.0 (28.5)	60.4 (22.0)	50.2 (20.4)	73.8 (24.8)	65.9 (43.9)	71.0 (17.9)
- 75 + years (N=19)	21.8 (22.4) [†]	34.2 (42.7) [#]	57.2 (24.6)	55.1 (24.5)	47.5 (20.2)	62.5 (36.1)	71.9 (37.3)	79.8 (18.3)

Values are mean (SD). ^{*}Significant difference compared to Australian norms ($P<0.01$); [†]Significantly lower than all other age groups ($P<0.05$); [#]Significantly lower than those aged 25-34 years and 45-54 years ($P<0.05$); ^{*}Significantly lower than those aged 25-34 years ($P<0.05$).

Note: SF-36 scored 0-100 in each dimension, where 0 represents extremely poor health and 100 is perfect health. Physical dimensions: physical functioning, impact of physical health on role performance (role physical), bodily pain, general health. Mental dimensions: vitality, social functioning, impact of emotional health on role performance (role emotional), general mental health.

SF-36 scores for a range of chronic diseases

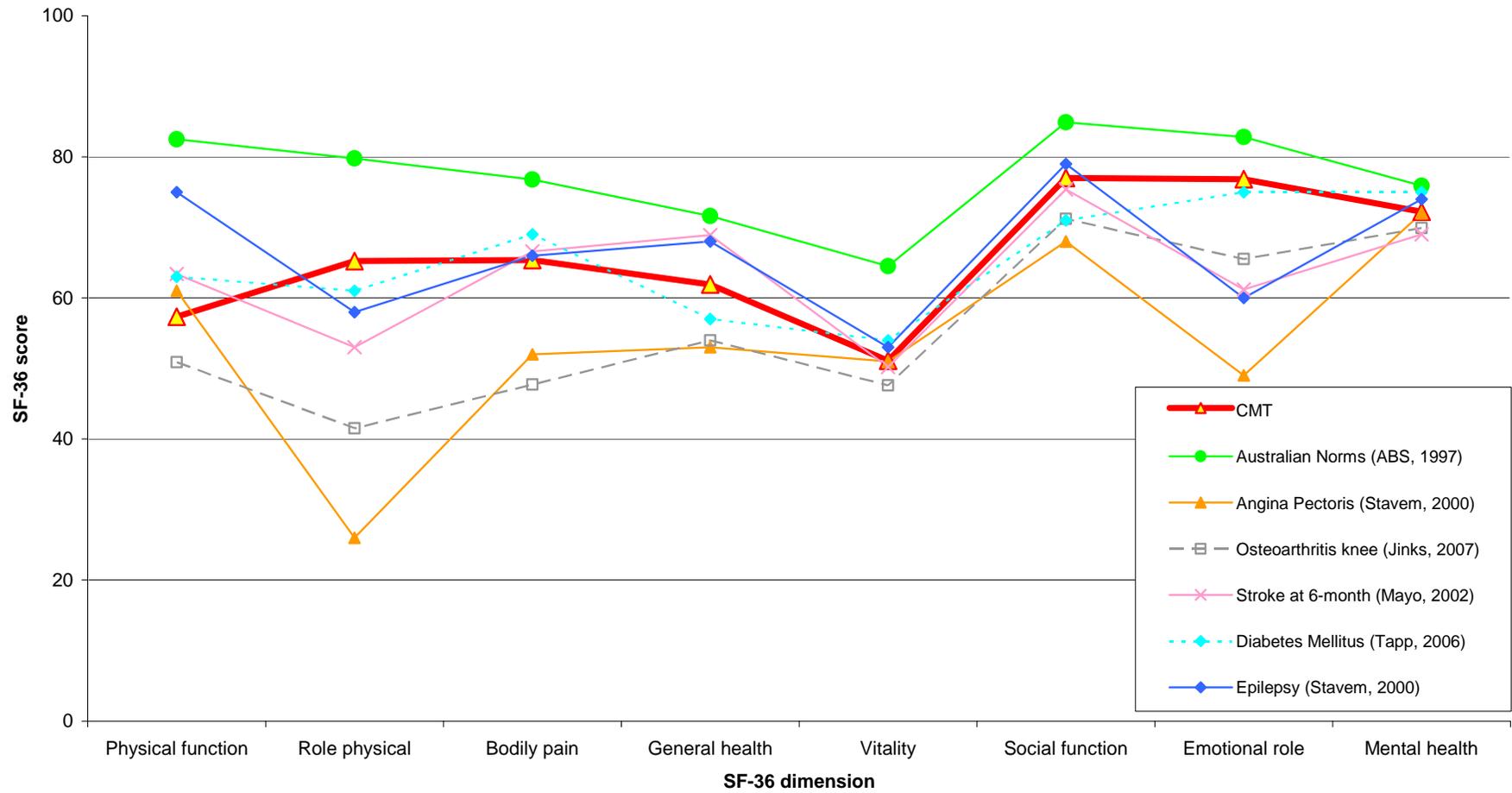


Table 2 Logistic regression modelling for predictors of SF-36 dimensions in CMT.

Predictors	Physical Function	Role Physical	Bodily Pain	General Health	Vitality	Social Function	Role Emotional	Mental Health
Age	1.82* (1.37-2.43) <i>P</i> <0.001	1.38* (1.07-1.79) <i>P</i> =0.013	0.89 (0.69-1.14) <i>P</i> =0.349	0.87 (0.68-1.12) <i>P</i> =0.280	1.28 (0.99-1.64) <i>P</i> =0.056	1.24 (0.96-1.59) <i>P</i> =0.096	1.23 (0.96-1.60) <i>P</i> =0.093	0.78 [†] (0.61-1.01) <i>P</i> =0.051
Gender	1.56 (0.91-2.68) <i>P</i> =0.109	0.87 (0.53-1.41) <i>P</i> =0.573	0.94 (0.57-1.53) <i>P</i> =0.795	0.97 (0.60-1.57) <i>P</i> =0.901	1.22 (0.76-1.99) <i>P</i> =0.412	1.31 (0.81-2.12) <i>P</i> =0.275	0.96 (0.59-1.56) <i>P</i> =0.861	1.42 (0.88-2.29) <i>P</i> =0.148
Marital status	0.57 (0.31-1.01) <i>P</i> =0.056	0.76 (0.45-1.29) <i>P</i> =0.307	1.05 (0.62-1.77) <i>P</i> =0.851	1.12 (0.67-1.88) <i>P</i> =0.658	0.97 (0.58-1.62) <i>P</i> =0.916	2.04* (1.21-3.34) <i>P</i> =0.007	0.59* (0.35-1.00) <i>P</i> =0.048	0.99 (0.60-1.64) <i>P</i> =0.971
CMT type	1.15 (0.63-2.12) <i>P</i> =0.655	0.94 (0.54-1.64) <i>P</i> =0.840	1.35 (0.77-2.38) <i>P</i> =0.297	1.12 (0.65-1.95) <i>P</i> =0.683	1.35 (0.77-2.34) <i>P</i> =0.296	0.93 (0.53-1.60) <i>P</i> =0.781	1.01 (0.57-1.77) <i>P</i> =0.983	0.95 (0.55-1.64) <i>P</i> =0.858
Leg/foot weakness	6.68* (3.91-11.43) <i>P</i> =0.001	2.40* (1.49-3.88) <i>P</i> =0.001	1.58 (0.98-2.58) <i>P</i> =0.062	2.69* (1.66-4.31) <i>P</i> =0.001	1.98* (1.23-3.20) <i>P</i> =0.005	2.05* (1.27-3.32) <i>P</i> =0.003	1.11 (0.68-1.81) <i>P</i> =0.667	2.23* (1.38-3.59) <i>P</i> =0.001
Leg cramps	2.02* (1.18-3.45) <i>P</i> =0.011	1.94* (1.18-3.18) <i>P</i> =0.009	3.65* (2.21-6.01) <i>P</i> =0.001	2.02* (1.24-3.30) <i>P</i> =0.005	2.00* (1.23-3.26) <i>P</i> =0.005	1.76* (1.08-2.85) <i>P</i> =0.023	1.86* (1.14-3.05) <i>P</i> =0.013	1.50 (0.93-2.42) <i>P</i> =0.096

Values are odds ratio (95% CI) and *P*-value.

Physical SF-36 dimensions: physical functioning, impact of physical health on role performance (role physical), bodily pain, general health. Mental SF-36 dimensions: vitality, social functioning, impact of emotional health on role performance (role emotional), general mental health.

*Significant predictor of HRQoL dimension (*P*<0.05); [†]Note: Younger people reported worse mental health score

Australian CMT Health Survey

About you

Y1. What is your gender?

Male Female

Y2. What is your marital status? (please tick one)

Single Married/ de facto Separated/divorced Widowed

Y3. What was your age last birthday?

Y4. At approximately what age did you first notice signs of CMT?

Y5. At approximately what age was your CMT formally diagnosed?

Y6. Were you incorrectly diagnosed as having another condition before being diagnosed as having CMT?

No Yes

Y6a. If yes, please give details. (Examples might include muscular dystrophy, polio, arthritis)

Y7. Which type of CMT do you have?

Not sure CMT1A ('hypertrophic' type) CMT1(other) ('hypertrophic' type – not chromosome 17)
CMT2 ('axonal' type) CMT3 (Dejerine-Sottas) CMTX (the 'x-linked' form)
Other
(please provide details)

Y8. Have you had a genetic test for CMT?

No Yes

Y9. Has your CMT type been confirmed by a genetic test?

(either in you or an immediate relative) No Yes

About your family

F1. Is there a history of CMT in your family?

No Not sure Yes

F1a. If yes, please provide details.

F2. Is yours considered a 'sporadic' case? (a one-off case with no family history)

No Not sure Yes

F3. Do you have any children?

No Yes

F3a. How many children do you have?

F3b. How many of your children have CMT?

F4. Do you have any other significant medical problems in addition to your CMT?

No Yes

F4a. If yes, please provide details.

Please turn the page and continue

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Women and pregnancy

If you are *male*, or a woman who has never been pregnant please skip this section and go straight to question B1 at the bottom of this page – 'CMT and your body'

P1. Were you diagnosed with CMT before your 1st pregnancy

No Yes

P1a. Did you receive any genetic counselling?

Yes No

P1b. Would you have liked to have had some genetic counselling?

No Yes Not sure

P2. For each of your pregnancies please indicate whether you experienced any worsening of your CMT symptoms while pregnant (eg weakness, more severe muscle wasting, pins and needles etc) –please complete a line for each pregnancy. Once you reach the last of your pregnancies either tick the box marked "Not applicable" or leave the rest of the lines blank.

	Your age at the time	Not Applicable	No change	A little worse	Worse	Much worse	Very much worse
Pregnancy number 1	_____	<input type="checkbox"/>					
Pregnancy number 2	_____	<input type="checkbox"/>					
Pregnancy number 3	_____	<input type="checkbox"/>					
Pregnancy number 4	_____	<input type="checkbox"/>					
Pregnancy number 5	_____	<input type="checkbox"/>					
Pregnancy number 6	_____	<input type="checkbox"/>					
Pregnancy number 7	_____	<input type="checkbox"/>					
Pregnancy number 8	_____	<input type="checkbox"/>					
Pregnancy number 9	_____	<input type="checkbox"/>					
Pregnancy number 10	_____	<input type="checkbox"/>					

If there was any change in your CMT due to pregnancy, please provide some information on the type of changes you experienced.

CMT and your body

Please indicate how severely you are affected by the following common features of CMT.

	Not at all	A little	A moderate amount	Quite a lot	Severely
B1. Scoliosis (a twist in your back)	<input type="checkbox"/>				
In your arms/hands -					
B2. Weakness	<input type="checkbox"/>				
B3. Muscle wasting	<input type="checkbox"/>				
B4. Tremor	<input type="checkbox"/>				
B5. Sensitivity to cold	<input type="checkbox"/>				
In your feet/legs -					
B6. Weakness	<input type="checkbox"/>				
B7. Muscle wasting	<input type="checkbox"/>				
B8. Sensitivity to cold	<input type="checkbox"/>				
B9. Flat feet	<input type="checkbox"/>				
B10. High arches	<input type="checkbox"/>				
<u>Other</u> (please comment)					

Please turn the page and continue

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CMT and your body - sensation

All of the questions in this section relate to how often you experience problems with sensation
Please tick the box which you feels best applies to you for each of the questions.

Never Occasionally Often Very often Constantly

Do you have problems with your...

- | | | | | | |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| S1. Hearing | <input type="checkbox"/> |
| S2. Vision (with seeing) | <input type="checkbox"/> |

Do you suffer from loss of sensation in:

- | | | | | | |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| S3. Your hands | <input type="checkbox"/> |
| S4. Your feet | <input type="checkbox"/> |

Do you have any problems with any of the following?

- | | | | | | |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| S5. Bladder control | <input type="checkbox"/> |
| S6. Bowel control | <input type="checkbox"/> |
| S7. Sexual function | <input type="checkbox"/> |

S8. Do you burn yourself?

(eg your hands while cooking, or feet when stepping into the bath)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

S9. Do you have slow reactions to pain?

(eg stub your toe and take quite a few seconds before noticing pain)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

Do you experience shooting pains?

- | | | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| S10. In your arms/hands | <input type="checkbox"/> |
| S11. In your legs/feet | <input type="checkbox"/> |

Do you experience 'pins and needles' or other strange sensations?

- | | | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| S12. In your arms/hands | <input type="checkbox"/> |
| S13. In your legs/feet | <input type="checkbox"/> |

S14. Do you have 'cramps' in your legs?

(cramps = painful spasms in the muscles)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

S15. Do you have 'restless' legs at night or when sitting?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

Please add any comments you would like to make about the changes in sensation associated with your CMT

CMT and you – impacts on daily function

F1. Do you use any of the following aids or devices? (please tick all that apply)

- | | | | |
|--|--------------------------|---|--------------------------|
| Wheelchair | <input type="checkbox"/> | Mobility scooter | <input type="checkbox"/> |
| Walking stick | <input type="checkbox"/> | Walking frame | <input type="checkbox"/> |
| Orthoses (inserts in your shoes) | | | |
| Low-cut 'in-shoe' orthoses | <input type="checkbox"/> | Other orthoses | |
| Splints coming above the ankle
(back slab or AFO type) | <input type="checkbox"/> | (please specify) | |
| Kitchen aids
(jar openers, large handled cutlery etc) | <input type="checkbox"/> | Dressing aids
(shoe horns, button aids etc) | <input type="checkbox"/> |

Please add any comments you would like to make about aids and devices.

Many people with CMT have problems finding comfortable footwear. For the benefit of other members however, **if you have found a type of shoe or a supplier who you feel has helped you, please supply details below.** (This information will not form part of the survey analysis but the list will be held by the CMTAA and provided to members.)

	Never	Occasionally	Often	Very often	Constantly
Do you lose your <u>balance</u> when:					
L1. You are walking on flat surfaces?	<input type="checkbox"/>				
L2. You are standing still?	<input type="checkbox"/>				
L3. You are walking on uneven surfaces?	<input type="checkbox"/>				
L4. Do you bend your knees to assist with your balance?	<input type="checkbox"/>				
L5. Do you fall <u>to the ground</u> because of balance problems	<input type="checkbox"/>				

Please add any comments you would like to make about your CMT and daily function

CMT and you – treatments (non-surgical)

Please indicate which of the following treatments you have tried. It would be very helpful if you could indicate **how easy** you found it to go through the treatment and **how effective** the treatment was for you.

Have you tried:

C1. Stretching exercises?

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C2. Ankle/foot splints (daytime wear)

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C3. Ankle/foot splints (night-time wear)

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C4. Shoe inserts (not above the ankle)

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C5. Plaster casts

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C6. Strengthening exercises (seated or lying down)

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

C7. Strengthening exercises (standing)

No	Yes	Approx date(s)	Ease	No difficulty	Minimal difficulty	Difficult	Very difficult	Impossible
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

CMT and you – treatments (alternative therapies)

Please indicate below if you have tried any alternative therapies (acupuncture, traditional Chinese medicine, naturopathy, aromatherapy, homoeopathy etc.) and indicate how easy you found it to go through the treatment and how effective the treatment was for you. If you have not tried any alternative therapies go straight to the next section.

Type of alternative therapy and date

A1.	Ease	No difficulty <input type="checkbox"/>	Minimal difficulty <input type="checkbox"/>	Difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Impossible <input type="checkbox"/>
	Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
A2.	Ease	No difficulty <input type="checkbox"/>	Minimal difficulty <input type="checkbox"/>	Difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Impossible <input type="checkbox"/>
	Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
A3.	Ease	No difficulty <input type="checkbox"/>	Minimal difficulty <input type="checkbox"/>	Difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Impossible <input type="checkbox"/>
	Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>

Please add any comments about the general conservative (non-surgical), **and/or** the alternative treatments you have tried.

CMT and you – treatments (surgery) foot only

Please indicate which of the following surgical treatments have been tried with you to improve your feet.

For many people there will be a complex history of several different approaches on several occasions. For the sake of keeping the form a manageable size, the list of options has been kept to a minimum.

If you wish to continue on a separate sheet please feel free to do so. (If you do add extra sheets listing multiple episodes of surgery, it would help us enormously if you can use the same format as in the questionnaire.)

In this section you are asked to tell us the approximate year you had the various surgeries, what age you were, what type of surgery you had and where, how traumatic the process was, how effective was the surgery technically, and how worthwhile you now consider subjecting your self to the surgery. In deciding how traumatic it was undergoing the surgery you should include: the amount of pain you suffered, the impact on your day-to-day life while you were healing from the surgery, and the length of time you were disabled by the surgery.

Please put a number in the box corresponding to the type of surgery you had, and then score your experience of the surgery.

<p>11 Muscle/tendon surgery – not sure what kind</p> <p>12 Bone surgery (osteotomy) – not sure what kind</p> <p>13 Joint fusion – not sure what kind</p>	<p>21 Tendon lengthening without transfer to a different place</p> <p>22 Tendon or muscle transfer without bony surgery</p>	<p>31 Bone surgery (osteotomy) without any joints fused – many bones operated on at the same time</p> <p>32 Bone surgery (osteotomy) without any joints fused – heel only</p> <p>33 Bone surgery (osteotomy) without any joints fused – arch area only</p> <p>34 Bone surgery (osteotomy) without any joints fused – front of foot only</p> <p>35 Bone surgery (osteotomy) and muscle/ tendon lengthening or transfer</p> <p>36 Toe straightening</p>	<p>41 Joint fusion – ‘Triple arthrodesis’</p> <p>42 Joint fusion – Ankle</p> <p>43 Joint fusion – Heel</p> <p>44 Joint fusion – Arch area</p> <p>45 Joint fusion – Front of foot only</p> <p>50 Other – (please specify)</p>
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EXAMPLE

Surgery type, place and approx date

<p>22 – tendon transfer –aged 17 (1980) West Coast Hospital, Sydney</p>	Trauma	None <input type="checkbox"/>	Some but manageable <input type="checkbox"/>	Unpleasant <input checked="" type="checkbox"/>	Very unpleasant <input type="checkbox"/>	Terrible <input type="checkbox"/>
	Effectiveness	Useless <input type="checkbox"/>	A little help <input checked="" type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
	Worthwhile	Definitely no <input type="checkbox"/>	Not really <input type="checkbox"/>	Neutral <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	Definitely yes <input type="checkbox"/>

Comments

It was very painful at first. I was able to walk within a month though so it could have been worse. It didn't really work as I have had to have a joint fusion since, but I suppose it bought me some time.

S1. Surgery type, place and approx date

<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	Trauma	None <input type="checkbox"/>	Some but manageable <input type="checkbox"/>	Unpleasant <input type="checkbox"/>	Very unpleasant <input type="checkbox"/>	Terrible <input type="checkbox"/>
	Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
	Worthwhile	Definitely no <input type="checkbox"/>	Not really <input type="checkbox"/>	Neutral <input type="checkbox"/>	Yes <input type="checkbox"/>	Definitely yes <input type="checkbox"/>

Comments

CMT and you – treatments (surgery) foot only

S2. Surgery type, place and approx date

Trauma	None <input type="checkbox"/>	Some but manageable <input type="checkbox"/>	Unpleasant <input type="checkbox"/>	Very unpleasant <input type="checkbox"/>	Terrible <input type="checkbox"/>
Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
Worthwhile	Definitely no <input type="checkbox"/>	Not really <input type="checkbox"/>	Neutral <input type="checkbox"/>	Yes <input type="checkbox"/>	Definitely yes <input type="checkbox"/>

Comments

S3. Surgery type, place and approx date

Trauma	None <input type="checkbox"/>	Some but manageable <input type="checkbox"/>	Unpleasant <input type="checkbox"/>	Very unpleasant <input type="checkbox"/>	Terrible <input type="checkbox"/>
Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
Worthwhile	Definitely no <input type="checkbox"/>	Not really <input type="checkbox"/>	Neutral <input type="checkbox"/>	Yes <input type="checkbox"/>	Definitely yes <input type="checkbox"/>

Comments

S4. Surgery type, place and approx date

Trauma	None <input type="checkbox"/>	Some but manageable <input type="checkbox"/>	Unpleasant <input type="checkbox"/>	Very unpleasant <input type="checkbox"/>	Terrible <input type="checkbox"/>
Effectiveness	Useless <input type="checkbox"/>	A little help <input type="checkbox"/>	Quite helpful <input type="checkbox"/>	Very helpful <input type="checkbox"/>	100% effective <input type="checkbox"/>
Worthwhile	Definitely no <input type="checkbox"/>	Not really <input type="checkbox"/>	Neutral <input type="checkbox"/>	Yes <input type="checkbox"/>	Definitely yes <input type="checkbox"/>

Comments

Please continue on a separate sheet if necessary (in the same format if possible)

CMT and you – treatments (surgery) foot only

Please tell us about the three most successful approaches to treatment you have tried. Please try to include why these approaches have been more successful than others.

M1

M2

M3

Please tell us about the two least successful approaches you have tried. Please try to include why these approaches have been less successful than others.

U1

U2

Please feel free to add any other comments regarding you, your experiences with CMT, or this survey (continue on a separate sheet if necessary).