This questionnaire is about your pain complaint. The information will be treated in complete confidence. For EACH question, TICK ONE box only unless instructed otherwise.

PATIENTS START HERE:

Q1 YOUR NAME

Q2 What place(s) do you feel most pain? (more than one box allowed)

Low Back ☐ Neck ☐ Shoulder/arm ☐
Leg ☐ Head ☐ Other ☐

Q3 If your pain is in your back or neck, does it go down into your leg(s)or arm(s)?

Yes ☐ No ☐

Q4 Would you describe your pain as generally 'ALL OVER' your body?

Yes ☐ No ☐

Q5 Is your painful complaint the result of A specific injury/trauma?

Yes ☐ No ☐ Don't Know ☐

Q6 Have you had this same or a similar complaint in the past?

Yes ☐ No ☐

Q7 How long has this PRESENT episode Of your painful complaint lasted?

Less than 7 weeks ☐
7 weeks or longer ☐

Q8 How often are you taking medication (painkillers and other drugs) for your complaint?

A lot of the time ☐
Occasionally/never ☐

Q9 How do you expect your condition to change in the next few weeks?

Recover/improve ☐
Stay about the same ☐
Get worse ☐

Q10 What is your current work status (tick ONE box only)?

Employed ☐ Retired ☐
Seeking work ☐ Working in the home ☐

Q11 Are you overall satisfied with your current work status?

Yes ☐ No ☐

Q12 In your estimation, do you expect to be working NORMALLY in 6 months time?

Yes/probably ☐
No/probably not ☐

Q13 Have you ever smoked?

Yes ☐ No ☐

Q14 Do you drink alcohol?

Weekly ☐ Never/hardly ever ☐

Q15 Compared with people of a similar age and in a similar position, how would you rate your level of physical activity?

More/about the same ☐
Less ☐

Q16 Apart from your complaint, how would you rate your GENERAL health and WELL-BEING?

Excellent/Good ☐
Fair/Poor ☐