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 □