

Name:	Date of Birth: dd/mm/yy
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During the **past week**, how bothersome have these symptoms **been**? (please circle to which you are referring)

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back and/or buttock pain	1	2	3	4	5	6
Leg pain	1	2	3	4	5	6
Numbness or tingling in leg and/or foot	1	2	3	4	5	6
Weakness in the leg and/or foot	1	2	3	4	5	6

Is your pain: Improving Staying the same Getting worse

Have there been any changes in your health since your last visit:

No Yes. Describe: _____

Have you had any changes to your medications since your last visit:

No Yes. Describe: _____

Have you tried any treatments for your pain since your last visit?

No Yes. Describe: _____

Has your employment status changed since your last visit?

No Yes. Describe: _____

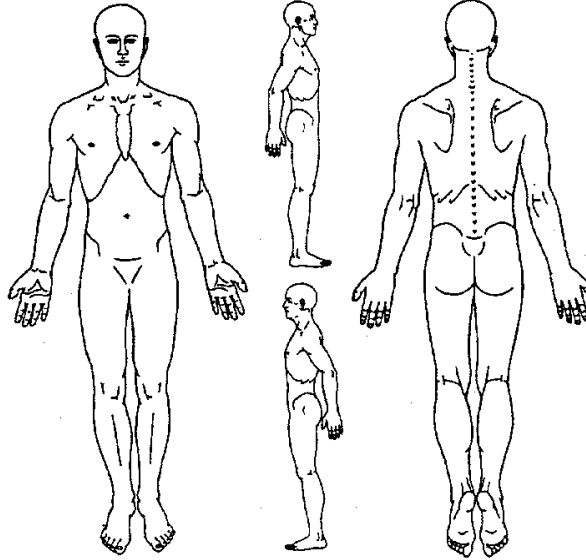
We would like to know how often you are exercising. In the past 7 days, how many times did you perform your prescribed low back pain exercises?

Everyday 4- 6 times 1 -3 times None

If you answered 'none', please check the reason that fits you best:

- I couldn't perform the exercises because of my lower back pain
- I couldn't perform the exercises because of another illness/condition
- I just didn't have the time
- I'm not certain how to do the exercises
- Honestly, I just wasn't interested in performing them
- Other (optional: specify _____)

Pain Diagram - Please mark the area of injury or discomfort on the chart below



Indicate below how you would rate your average pain level during the past week in your back and leg(s) (as applicable), ranging from 'No pain' to 'Worst possible pain you can imagine'.

Back pain at its best:

0 1 2 3 4 5 6 7 8 9 10
No pain *Worst possible pain*

Back pain at its worst:

0 1 2 3 4 5 6 7 8 9 10
No pain *Worst possible pain*

Leg pain at its best:

0 1 2 3 4 5 6 7 8 9 10
No pain *Worst possible pain*

Leg pain at its worst:

0 1 2 3 4 5 6 7 8 9 10
No pain *Worst possible pain*

How long can you comfortably?

Activity:	Sit	Stand	Walk	Sleep
Time:	_____ mins	_____ mins	_____ mins	_____ hrs

ODI

DIRECTIONS: Answer every question by marking the correct box. If you need to change an answer, completely scratch out the incorrect answer and mark the correct box. If you are unsure about how to answer a question, please give the best answer you can. Mark only one answer for each question unless instructed otherwise.

<p>1. PAIN INTENSITY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. 	<p>6. STANDING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without extra pain. <input type="checkbox"/> I can stand as long as I want but it gives extra pain. <input type="checkbox"/> Pain prevents me from standing more than 1 hour. <input type="checkbox"/> Pain prevents me from standing more than 1/2 an hour. <input type="checkbox"/> Pain prevents me from standing more than 10 minutes. <input type="checkbox"/> Pain prevents me from standing at all.
<p>2. PERSONAL CARE (WASHING, DRESSING, ETC):</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it is very painful. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self-care. <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed. 	<p>7. SLEEPING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sleep is never disturbed by pain <input type="checkbox"/> My sleep is occasionally disturbed by pain. <input type="checkbox"/> Because of pain I have less than 6 hours sleep. <input type="checkbox"/> Because of pain I have less than 4 hours sleep. <input type="checkbox"/> Because of pain I have less than 2 hours sleep. <input type="checkbox"/> Pain prevents me from sleeping at all.
<p>3. LIFTING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g on a table). <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift only very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. 	<p>8. SEX LIFE (if applicable):</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sex life is normal and causes no extra pain. <input type="checkbox"/> My sex life is normal but causes some extra pain. <input type="checkbox"/> My sex life is nearly normal but is very painful. <input type="checkbox"/> My sex life is severely restricted by pain <input type="checkbox"/> My sex life is nearly absent because of pain. <input type="checkbox"/> Pain prevents any sex life at all.
<p>4. WALKING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me walking more than 1 mile. <input type="checkbox"/> Pain prevents me walking more than 1/2 mile. <input type="checkbox"/> Pain prevents me walking more than 1/4 mile. <input type="checkbox"/> I can only walk using a stick or crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. 	<p>9. SOCIAL LIFE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and causes me no extra pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, sports) <input type="checkbox"/> Pain has restricted my social life and I do not go out as often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have no social life because of pain
<p>5. SITTING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favourite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting more than 1/2 an hour. <input type="checkbox"/> Pain prevents me from sitting more than 10 minutes. <input type="checkbox"/> Pain prevents me from sitting at all. 	<p>10. TRAVELLING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without pain. <input type="checkbox"/> I can travel anywhere but it gives extra pain. <input type="checkbox"/> Pain is bad but I manage journeys over two hours. <input type="checkbox"/> Pain restricts me to journeys less than one hour. <input type="checkbox"/> Pain restricts me to short journeys under 30 minutes. <input type="checkbox"/> Pain prevents me from traveling except to receive treatment

EQ-5D

Under each heading, please tick the **ONE** box that best describes your health **TODAY**:

MOBILITY:

- I have no problems walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

SELF-CARE:

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

USUAL ACTIVITIES (eg., work, study, housework, family or leisure activities):

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

PAIN/DISCOMFORT:

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

ANXIETY/DEPRESSION:

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

STarT Back

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree	Agree
	0	1
1. My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2. I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3. I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4. In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5. It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6. Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7. I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8. In general, I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>
9. Overall, how bothersome has your back pain been in the last 2 weeks ?		
Not at all Slightly Moderately Very much Extremely		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
0 0 0 1 1		

Total score (all 9): _____ **Sub Score (Q5-9):** _____