

BQ PRE-TREATMENT QUESTIONNAIRE

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

CONTINUED OVERLEAF