

BeST

Core Outcome measures for 3 Month questionnaire non-responders

Participant Study Number:

Date of telephone interview:

The first questions are about how much your back trouble has been interfering with your daily activities in recent weeks.

1. In the **past 4 weeks**, how much has your back pain interfered with your daily activities on a scale of 0-10 where 0 is 'no interference' and 10 is 'unable to carry out any activities at all'?
0 1 2 3 4 5 6 7 8 9 10
2. In the **past 4 weeks**, how much has your back pain changed your ability to take part in recreational, social and family activities on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?
0 1 2 3 4 5 6 7 8 9 10
3. In the **past 4 weeks**, how much has your back pain changed your ability to work (including housework) on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?
0 1 2 3 4 5 6 7 8 9 10
4. In the **past 4 weeks**, how bad has your worst back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?
0 1 2 3 4 5 6 7 8 9 10
5. In the **past 4 weeks**, on average how bad has your back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?
0 1 2 3 4 5 6 7 8 9 10
6. How would you rate your back pain **today** on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?
0 1 2 3 4 5 6 7 8 9 10

7. In what way has your back pain changed in the past three months?

| | | | |
|----------------------|----------------------------|---------------|----------------------------|
| Completely recovered | <input type="checkbox"/> 1 | Much improved | <input type="checkbox"/> 2 |
| Slightly improved | <input type="checkbox"/> 3 | No change | <input type="checkbox"/> 4 |
| Slightly worsened | <input type="checkbox"/> 5 | Much worsened | <input type="checkbox"/> 6 |
| Vastly worsened | <input type="checkbox"/> 7 | | |

The next questions are about your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

| | | | | | |
|--|----------------------------|----------------------------|----------------------------|------------------------------|-------------------------------|
| 8. In general, would you say your health is: | | | | | |
| Excellent | Very good | Good | Fair | Poor | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 9. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? | | | | | |
| | | | Yes, limited a lot | Yes, limited a little | No, not limited at all |
| a) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b) Climbing several flights of stairs | | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 10. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health ? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 11. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 12. During the past 4 weeks , how much did pain interfere with your normal work (including both work outside the home and housework)? | | | | | |
| Not at all | A little bit | Moderately | Quite a bit | Extremely | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |

13. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. **How much of the time during the past 4 weeks:**

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---------------------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| a) Have you felt calm and peaceful? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c) Have you felt downhearted and low? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

14. During the **past 4 weeks**, how much of the time has your physical health OR emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

The following questions are to ask about your general health state at the moment please let me know which statement best describes your own health state today.

15. Mobility:

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

16. Self-Care:

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

17. Usual Activities (e.g. work, study, housework, family or leisure activities):

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

16. Pain / Discomfort:

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

17. Anxiety / Depression:

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Changes in work status in the last three months

20. Have you had to take any days off sick from work in the last three months due to your low back pain?

Yes 1

If **Yes**, how many days?

No 2

Not applicable? 3

21. Have your hours of employment altered in the last three months because of changes in your back pain?

No, stayed the same 1

Yes, increased 2

Yes, decreased 3

Not applicable 4

If **Yes**, by how many hours per week has your employment changed? _____

When did this change occur?

22. If you were off work when you joined the study, have you returned to work?

1 I am still off work

2 I returned to work on | |

3 Not applicable?

Advise patient of 6 month questionnaire and importance of completing it and returning it in pre-paid envelope

BeST

Core Outcome measures for 6 Month questionnaire non-responders

Participant Study Number:

Date of telephone interview:

The first questions are about how much your back trouble has been interfering with your daily activities in recent weeks.

1. In the **past 4 weeks**, how much has your back pain interfered with your daily activities on a scale of 0-10 where 0 is 'no interference' and 10 is 'unable to carry out any activities at all'?

0 1 2 3 4 5 6 7 8 9 10

2. In the **past 4 weeks**, how much has your back pain changed your ability to take part in recreational, social and family activities on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?

0 1 2 3 4 5 6 7 8 9 10

3. In the **past 4 weeks**, how much has your back pain changed your ability to work (including housework) on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?

0 1 2 3 4 5 6 7 8 9 10

4. In the **past 4 weeks**, how bad has your worst back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

5. In the **past 4 weeks**, on average how bad has your back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

6. How would you rate your back pain **today** on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

7. How would you describe your back pain compare to when you started the study?

Very much improved (or completely recovered) 1

Minimally (or slightly) improved 3

Minimally worse 5

Very much worse 7

Much improved 2

No change 4

Much worse 6

The next questions are about your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

| | | | | | |
|--|----------------------------|-----------------------------------|--------------------------------------|-----------------------------------|----------------------------|
| 8. In general, would you say your health is: | | | | | |
| Excellent | Very good | Good | Fair | Poor | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 9. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? | | | | | |
| | | Yes, limited a lot | Yes, limited a little | No, not limited at all | |
| a) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| b) Climbing several flights of stairs | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| 10. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health ? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 11. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 12. During the past 4 weeks , how much did pain interfere with your normal work (including both work outside the home and housework)? | | | | | |
| Not at all | A little bit | Moderately | Quite a bit | Extremely | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |

13. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. **How much of the time during the past 4 weeks:**

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---------------------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| a) Have you felt calm and peaceful? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c) Have you felt downhearted and low? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

14. During the **past 4 weeks**, how much of the time has your physical health OR emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

The following questions are to ask about your general health state at the moment please let me know which statement best describes your own health state today.

15. Mobility:

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

16. Self-Care:

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

17. Usual Activities (e.g. work, study, housework, family or leisure activities):

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

16. Pain / Discomfort:

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

17. Anxiety / Depression:

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

Changes in work status in the last three months

20. Have you had to take any days off sick from work in the last three months due to your low back pain?

- Yes 1 If **Yes**, how many days?
- No 2
- Not applicable? 3

21. Have your hours of employment altered in the last three months because of changes in your back pain?

- No, stayed the same 1
- Yes, increased 2
- Yes, decreased 3
- Not applicable 4

If **Yes**, by how many hours per week has your employment changed? _____

When did this change occur?

22. If you were off work when you joined the study, have you returned to work?

- 1 I am still off work
- 2 I returned to work on
- 3 Not applicable?

Advise patient of 12 month questionnaire and importance of completing it and returning it in pre-paid envelope

BeST

Core Outcome measures for 12 Month questionnaire non-responders

Participant Study Number:

Date of telephone interview:

The first questions are about how much your back trouble has been interfering with your daily activities in recent weeks.

1. In the **past 4 weeks**, how much has your back pain interfered with your daily activities on a scale of 0-10 where 0 is 'no interference' and 10 is 'unable to carry out any activities at all'?

0 1 2 3 4 5 6 7 8 9 10

2. In the **past 4 weeks**, how much has your back pain changed your ability to take part in recreational, social and family activities on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?

0 1 2 3 4 5 6 7 8 9 10

3. In the **past 4 weeks**, how much has your back pain changed your ability to work (including housework) on a scale of 0-10 where 0 is 'no change' and 10 is 'extreme change'?

0 1 2 3 4 5 6 7 8 9 10

4. In the **past 4 weeks**, how bad has your worst back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

5. In the **past 4 weeks**, on average how bad has your back pain been on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

6. How would you rate your back pain **today** on a scale of 0-10 where 0 is 'no pain' and 10 is 'as bad as a pain could be'?

0 1 2 3 4 5 6 7 8 9 10

7. How would you describe your back pain compare to when you started the study?

Very much improved (or completely recovered) 1

Minimally (or slightly) improved 3

Minimally worse 5

Very much worse 7

Much improved 2

No change 4

Much worse 6

The next questions are about your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

| | | | | | |
|--|----------------------------|----------------------------|----------------------------|------------------------------|-------------------------------|
| 8. In general, would you say your health is: | | | | | |
| Excellent | Very good | Good | Fair | Poor | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 9. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? | | | | | |
| | | | Yes, limited a lot | Yes, limited a little | No, not limited at all |
| a) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b) Climbing several flights of stairs | | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 10. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health ? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 11. During the past 4 weeks , how much of the time have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? | | | | | |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 12. During the past 4 weeks , how much did pain interfere with your normal work (including both work outside the home and housework)? | | | | | |
| Not at all | A little bit | Moderately | Quite a bit | Extremely | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |

13. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. **How much of the time during the past 4 weeks:**

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---------------------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| a) Have you felt calm and peaceful? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c) Have you felt downhearted and low? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

14. During the **past 4 weeks**, how much of the time has your physical health OR emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

The following questions are to ask about your general health state at the moment please let me know which statement best describes your own health state today.

15. Mobility:

- I have no problems in walking about
- I have some problems in walking about
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- I have no problems with self-care
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17. Usual Activities (e.g. work, study, housework, family or leisure activities):

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

16. Pain / Discomfort:

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

17. Anxiety / Depression:

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Changes in work status in the last three months

20. Have you had to take any days off sick from work in the last three months due to your low back pain?

Yes

 1

If **Yes**, how many days?

No

 2

Not applicable? 3

21. Have your hours of employment altered in the last three months because of changes in your back pain?

No, stayed the same

 1

Yes, increased

 2

Yes, decreased

 3

Not applicable

 4

If **Yes**, by how many hours per week has your employment changed? _____

When did this change occur?

22. If you were off work when you joined the study, have you returned to work?

1 I am still off work

2 I returned to work on

3 Not applicable?

*Thank patient for taking part in the study and advise that this
Was their final questionnaire*