National Institute for Health Research

Keele University

Follow-up Questionnaire

- Thank you for filling in our questionnaire. Your help is much appreciated.
- There are no 'correct' or 'incorrect' answers. Answer according to your own feelings, rather than how you think most people will answer.
- When you've finished, just return the questionnaire in the envelope provided. **You do not need a stamp.**
- If you have any questions, please contact Mel Holden, the EASE BACK study co-ordinator on **01782 733921** during office hours.

Thank you very much for your help with this research study

INSTRUCTIONS FOR THIS QUESTIONNAIRE

It is important to answer **all** the questions, even if you feel that they do not apply to you. Some questions may look like others, but they tell us different things, so all are important to answer. Some of the questions are arranged in sections according to the period of time that they ask about.

Many of the questions are about your pain. Some questions are about work, and others are about you and your general health. Please take the time to read and answer each question carefully.

Most of the questions can be answered by putting a **cross** in a box next to or under your answer. For example, if you wish to answer 'Not at all', **cross** the box like this:

Not at all	Slightly	Moderately	Very much	Extremely
X				

Here is an example of how to answer a question if you **don't** have any pain:

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10
X										

Now please continue and fill in this questionnaire

Section A - Your back problem

1. In the **last 2 weeks**, on **average**, how intense was your **usual** back pain rated on a 0–10 scale, where 0 is 'no pain' and 10 is 'pain as bad as could be'?
*(Please cross **one** box only)*

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. In the **last 2 weeks**, how intense was your **least** painful back pain rated on a 0–10 scale, where 0 is 'no pain' and 10 is 'pain as bad as could be'?
*(Please cross **one** box only)*

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. In the **last 2 weeks**, on **average**, how intense was your back pain **just before going to bed at night**, rated on a 0-10 scale, where 0 is 'no pain' and 10 is 'pain as bad as could be'?
*(Please cross **one** box only)*

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. During the **last 2 weeks**, how often has your back pain **prevented you** from **falling asleep**?
*(Please cross **one** box only)*

No nights	**Only 1 or 2 nights**	**Some nights**	**Most nights**	**Every night**
☐	☐	☐	☐	☐

5. During the **last 2 weeks**, how often has your back pain **woken you up** at night?
*(Please cross **one** box only)*

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
☐	☐	☐	☐	☐

6. How would you rate your **pain** on a 0-10 scale **at the present time**, that is, right now, where 0 is 'no pain' and 10 is 'pain as bad as could be'?
*(Please cross **one** box only)*

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. Compared with when you completed your first EASE BACK study questionnaire, approximately 8 weeks ago, how would you say your back pain problem is now?
*(Please cross **one** box only)*

Completely recovered	Much improved	Somewhat improved	Same	Somewhat worse	Much worse
☐	☐	☐	☐	☐	☐

8. The following questions on pages 5, 6 and 7 have been designed to give us information as to how your **back pain** is affecting your ability to manage in everyday life. Please answer by crossing **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply, but please just put a cross in the **one box** that indicates the statement which **most closely describes your problem**.

Section 1: Pain Intensity

☐ I have no pain at the moment

☐ The pain is very mild at the moment

☐ The pain is moderate at the moment

☐ The pain is fairly severe at the moment

☐ The pain is very severe at the moment

☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (e.g. washing, dressing)

☐ I can look after myself normally without causing extra pain

☐ I can look after myself normally but it causes extra pain

☐ It is painful to look after myself and I am slow and careful

☐ I need some help but can manage most of my personal care

☐ I need help every day in most aspects of self-care

☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐ Not applicable

☐ I can lift heavy weights without extra pain

☐ I can lift heavy weights but it gives me extra pain

☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (e.g. on a table)

☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned

☐ I can only lift very light weights

☐ I cannot lift or carry anything

Section 4: Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Please continue to answer the questions by putting a cross in the **one box** that indicates the statement which most clearly describes your problem.

Section 8: Sex Life

- ☐ Not applicable
- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

For the following questions, please tell us to **what extent you find it problematic** to carry out the activities listed below **because of your back pain**.

For each activity, please **cross one box** that best describes how you are **today.**

How problematic it is for you, because of your back pain to:

	Not at all problematic	To a small extent	To some extent	To a large extent	Not applicable
9. Dress yourself………………………	☐	☐	☐	☐	☐
10. Stand for less than 10 minutes…….	☐	☐	☐	☐	☐
11. Stand for more than 60 minutes…..	☐	☐	☐	☐	☐
12. Bend down………………………….	☐	☐	☐	☐	☐
13. Sit for less than 10 minutes……….	☐	☐	☐	☐	☐
14. Sit for more than 60 minutes………	☐	☐	☐	☐	☐
15. Walk for less than 10 minutes…….	☐	☐	☐	☐	☐
16. Walk for more than 60 minutes……	☐	☐	☐	☐	☐
17. Climb stairs…………………………	☐	☐	☐	☐	☐
18. Do housework………………………	☐	☐	☐	☐	☐
19. Carry light objects…………………..	☐	☐	☐	☐	☐
20. Carry heavy objects………………..	☐	☐	☐	☐	☐
21. Get up/ sit down……………………	☐	☐	☐	☐	☐
22. Push a shopping trolley……………	☐	☐	☐	☐	☐
23. Run……………………………………	☐	☐	☐	☐	☐
24. Carry out sporting activities……….	☐	☐	☐	☐	☐
25. Lie down…………………………….	☐	☐	☐	☐	☐
26. Roll over in bed……………………..	☐	☐	☐	☐	☐
27. Have a normal sex life……………..	☐	☐	☐	☐	☐
28. Push something with one foot…….	☐	☐	☐	☐	☐

Please answer the following questions by putting a cross in **one** box.

29. How much back pain do you experience:

	None	Some	Moderate	Considerable
a. In the morning................................				
b. In the evening.................................				

30. To what extent because of your back pain:

	Not at all	To a small extent	To some extent	To a large extent
a. Has your leg/ legs given way?...............				
b. Do you do things more slowly?..............				
c. Is your sleep interrupted?				

Section B - Your general health

In the following section we are asking for your views about your general health.

For the following questions, please **cross one box on each line** that best describes your answer. Remember to think about your **general health** at **present.**

1. In **general**, would you say your health is…

Excellent	Very good	Good	Fair	Poor

2. 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, bowling or playing golf……………………………………………….	☐	☐	☐
b)	Climbing **several** flights of stairs………………	☐	☐	☐

3. During the **last week**, 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………………………	☐	☐	☐	☐	☐
b)	Were limited in the **kind of work** or other activities………	☐	☐	☐	☐	☐

4. During the **last week**, 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 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……………………	☐	☐	☐	☐	☐
b)	Did work or **activities less carefully** than usual…………	☐	☐	☐	☐	☐

Remember to think about your **general health** at **present.**

5. During the **last week** how much did **pain** interfere with your normal work (including work both outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

These questions are about how you feel and how things have been with you during the **last week**. For each question, please give the one answer that comes closest to the way you have been **feeling**.

6. How much time during the last week:

	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?...........................	☐	☐	☐	☐	☐
b) Did you have a lot of energy?	☐	☐	☐	☐	☐
c) Have you felt downhearted and depressed?..................	☐	☐	☐	☐	☐

7. During the **last week**, how much of the time has your physical health or emotional problems interfered with your **social activities** (like visiting friends, relatives, etc.)?

All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
☐	☐	☐	☐	☐

Under each heading, please put a cross in the one box that best describes your health today.

8. **MOBILITY**

- [ ] I have no problems in 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

9. **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

10. **USUAL ACTIVITIES (e.g. 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

11. **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

12. **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

Section C - About you

1. What is your **date of birth**? [ ][ ] [ ][ ] [1][9][ ][ ]

2. Are you still pregnant?

Yes................ ☐ No.................. ☐

If yes, how many weeks pregnant are you?

[ ] Weeks [ ] days

3. Which of the following best describes your **current** situation (we realise that you may currently be on maternity leave)? *(Please cross **one** box)*

Working full-time in a paid job…………………………………… ☐

Working part-time in a paid job………………………………… ☐

Employed but currently off sick due to back pain……………. ☐

Employed but currently off sick due to other health reason … ☐

Employed but currently on maternity leave…………………. ☐

*Please continue with **question 4***

Housewife/ stay at home mum………………………………… ☐

Unemployed due to back pain…………………………………. ☐

Unemployed for other health reason…………………………. ☐

Unemployed for other reason…………………………………. ☐

Student………………………………………………………… ☐

Other *(please specify)*………………………………………… ☐

……………………………………………………………………………

*Please continue with **section D, on page 18***

4. Have you **taken time off work** during the **last 8 weeks** (since your last EASE BACK study questionnaire) because of your back pain?

Yes……………. ☐ No……………… ☐

If yes, please write the **total number** of days, weeks or months you were off work due to your back pain **since the last EASE BACK study questionnaire**.

☐ Days

☐ Weeks

☐ Months

*Please only enter a number in **one** of these boxes*

5. On average, to what extent has your back pain affected your **performance at work** since the last EASE BACK study questionnaire (approximately 8 weeks ago? *(Please put a cross in **one** box only)*

Not at all										**The pain is so bad that I am unable to do my job**
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. Did you receive treatment from a physiotherapist as part of the EASE BACK study?

☐ Yes → *Please continue to answer all the questions in this section*

☐ No → *Please go to section D, on page 18*

The following questions are important because they will help us to understand the cost to you when attending your physiotherapy appointments as part of the EASE BACK study.

7. Did you have to take any time off work to attend any of the physiotherapy appointments?

☐ Yes → *Please continue and answer question 8*

☐ No → *Please go to question 11 on the next page (page 16)*

8. How much time did you have to take off work to attend any **one** of these physiotherapy appointments?

.. ..hours ....minutes

9. Were you paid during this time off? *(Please put a cross in **one** box only)*

Yes.......................... ☐

No........................... ☐

I'm self-employed..... ☐

10. What was the main way your absence from work was dealt with while you attended any one of the physiotherapy appointments? *(please cross **all** that apply)*

Work was done by colleagues in addition to their own work.............. ☐

Someone was employed temporarily to cover............................... ☐

I had to catch up by doing extra hours when I returned to work......... ☐

The work was not done or it was put off until a further date.............. ☐

Other, please specify... ☐

....

11. Did you have to reduce your time spent on unpaid activities (e.g. voluntary work, leisure pursuits, family and domestic responsibilities) to attend any one of the physiotherapy appointments?

☐ Yes ⟶ *Please answer questions (a) and (b) below*

☐ No ⟶ *Please go to question 12 on the next page (page 17)*

a) Approximately how much time was affected? ....hours ....minutes

b) What types of activities were affected *(please cross **all** that apply)*

Looking after children .... ☐

Looking after other relatives .... ☐

Leisure activities .... ☐

Housework .... ☐

Studying.. ☐

Other, please specify........................... ☐

....

12. If looking after children or other relatives was affected, did you pay someone to look after them in your absence?

Yes………………….... ☐ → If yes, how much did it cost? £……..:……..p.

No………………….…. ☐

Not applicable………. ☐

13. Did someone accompany you to any **one** of your physiotherapy appointments?

Yes……………. ☐ No……………… ☐

14. When you attended any **one** of your physiotherapy appointments, what form of transport did you use? (*please cross **one** box only*)

Car/ van……………............ ☐ → *Please go to question 15*

Motorbike/ scooter…………. ☐ → *Please go to question 15*

Taxi/ train/ bus……………. ☐ → *Please go to question 16*

On foot……………………... ☐ → *Please go to **section D**, on page 18*

15. If you travelled by car, van or motorbike/scooter:

a) Approximately how many miles was the return journey? …………………. Miles

b) Did you have to pay to park?

Yes………………….... ☐ → c) It cost: £……..:……..p.

No………………….…. ☐

16. If you travelled by train, bus or taxi, how much was the return fare? £……..:……..p.

Section D - Treatment and care

This section is about **ALL** the health care you have received for your **back pain or related symptoms**.

1. During the **last 8 weeks** (since your last EASE BACK study questionnaire), have you personally bought any **over-the-counter medicines** (items that you buy from the chemist / supermarket), **treatments** or **appliances** to help your **back pain**?

These can include painkillers, creams, sprays, heat pads, massage oils, TENS machine, belts or corsets etc, as well as any herbal or complementary remedies. *(Please cross **one** box)*

Yes........... ☐ *Please complete the table below to give us some details*

No............ ☐ *Please turn to **question 2** on the next page (page 19)*

Please give details of all the medicines or treatments you have used for your back pain in the **last 8 weeks** (since your last EASE BACK study questionnaire)...

Medicine / treatment / appliance	Cost (£)
For example - support belt/ brace	*£9.50*

2. During **the last 8 weeks** (since your last EASE BACK study questionnaire), have you been **prescribed any medicines, treatments or appliances** (e.g. painkillers, TENS, heat pads) for your **back pain**?
(Please cross ***one*** *box)*

Yes……….. ☐ *Please complete the table below to give us some details*

No………… ☐ *Please continue to answer* ***question 3*** *on the next page (page 20)*

Please give details of all treatments or medications you have been prescribed for your back pain in the **last 8 weeks** (since your last EASE BACK study questionnaire) ….

Medicine/ appliance prescribed	Tablets per day	Dosage per tablet	Length of supply
Example	*3*	*200mg*	*1 month*

3. In the last **8 weeks** (since you last EASE BACK study questionnaire), apart from any EASE BACK treatment visits, have you attended for NHS or private health care **because of your back problem**? This may include inpatient stays, visits to accident and emergency, other physiotherapy treatments, treatments received at your family doctor's surgery, or extra visits to your midwife.

Yes……….. ☐ *Please provide details in the table below*

No…………. ☐ *Please continue with question 4 on page 21*

Please write in the table below the number of times you have seen each type of health professional (**for your back pain**) in the **last 8 weeks** (since your last EASE BACK study questionnaire). Any treatments or investigations or investigations you may have received as a result of these consultations (e.g. x-rays, surgeries, injections) are covered later in the questionnaire and should not be reported here.

Health care professional	Number of visits in NHS	Number of visits in private practice
For example – Doctor (GP)	*3*	*0*
Doctor (GP)		
Midwife		
Physiotherapist		
Health visitor		
Acupuncturist		
Obstetrician		
Practice/ District nurse		
Occupational therapist		
Rheumatologist		
Other (please specify) ………………………………………………………………		
Other (please specify) ………………………………………………………………		

4. In the **last 8 weeks** (since you last EASE BACK study questionnaire) have you attended an NHS or private health care centre for any investigations or treatments (e.g. x-ray, surgery, injection) for your back pain? Please do not include any initial appointments reported in the previous question.

Yes.......... ☐ *Please provide details in the table below*

No........... ☐ *Please continue with question 5 below*

In the table below, please give details of each investigation or treatment you have received in the **last 8 weeks** (since you last EASE BACK study questionnaire) …

Treatment or investigation	Reason for attendance	Number of days at or in hospital
e.g. injection	*Increase in back pain*	*1*

The following section asks about the information/ treatment you received within the EASE BACK study.

5. How **confident** do you feel that the information/ treatment you received **helped your back pain problem**? *(Please cross **one** box only)*

Very confident	Quite confident	No opinion	Not very confident	Not confident at all
☐	☐	☐	☐	☐

6. How **confident** would you be in **recommending this information/ treatment to a friend** who suffered from a similar problem?
*(Please cross **one** box only)*

Very confident	Quite confident	No opinion	Not very confident	Not confident at all
☐	☐	☐	☐	☐

7. How **logical** did the **information/ treatment** seem to you?
*(Please cross **one** box only)*

Not at all logical	Not very logical	No opinion	Quite logical	Very logical
☐	☐	☐	☐	☐

8. How **successful** do you think **the information/ treatment you received** would be in **alleviating other complaints**?
*(Please cross **one** box only)*

Not at all successful	Not very successful	No opinion	Quite successful	Very successful
☐	☐	☐	☐	☐

9. Do you believe that you have had any side effects as a direct cause of treatment package that you have received in the EASE BACK study?
*(Please cross **one** box only)*

Yes……….. ☐ *Please continue with question 10 on the next page (page 23)*

No………… ☐ *Please continue with question 11 on the next page (page 23)*

10. We would like to know more about any side effects of the EASE BACK treatment packages. Please **put a cross in any box that applies to you**:

Nausea	☐
Vomiting...........................	☐
Drowsiness/ light headedness...........	☐
Fainting	☐
Bruising...	☐
Feeling hot/ burning.........................	☐
Headaches..............	☐
Pain/ soreness............	☐
Other (please specify).....................	☐

....

11. How **satisfied** are you with the **treatment package you received** in the EASE BACK study concerning your back pain problem? *(Please cross **one** box)*

Very dissatisfied	Quite dissatisfied	No opinion	Quite satisfied	Very satisfied
☐	☐	☐	☐	☐

12. How **satisfied** are you with the **results from the treatment** you received in the EASE BACK study for your back problem? *(Please cross **one** box)*

Very dissatisfied	Quite dissatisfied	No opinion	Quite satisfied	Very satisfied
☐	☐	☐	☐	☐

Comments

If you have any other comments about your back problem or the care you have received in the EASE BACK study, please write them in the space below.

Thank you for taking the time to fill in this questionnaire, your answers will be very useful to us.

We assure you that any information will be held in strictest confidence.

Now please return this questionnaire in the prepaid envelope provided. You do not need a stamp. If you have any questions about this questionnaire or the study in general please contact Mel Holden, the study co-ordinator, on **01782 733921** during office hours.

Thank you very much for your help.

Study ID (Office Use Only)