*** We are interested in learning how your illness affects your ability to function in daily life. Please tick (✓) the ONE best answer that describes your usual abilities OVER THE PAST WEEK:**

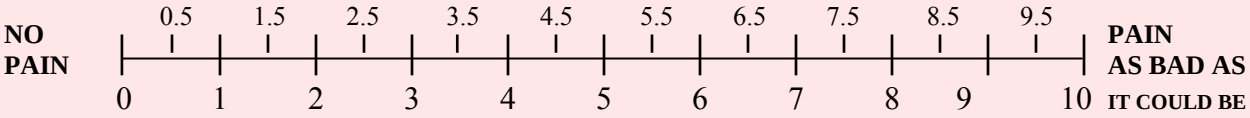
HAQ

Over the LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable TO DO
1. Get on and off the toilet?	……..	…….	…….	…….
2. Open car Doors?	…….	…….	…….	……
3. Stand up from a straight chair?	…….	…….	…….	…….
4. Walk outdoors on flat ground?	…….	…….	…….	…….
5. Wait in a line for 15 minutes?	…….	…….	…….	…….
6. Reach and get down a 5-pounds-object (such as a bag of sugar) from just above your head?	…….	…….	…….	…….
7. Go up 2 or more flights of stairs?	……	…….	…….	…….
8. Do outside work (such as yard work)	……	…….	…….	…….
9. Lift heavy objects?	…….	…….	…….	…….
10. Move heavy objects?	…….	…….	…….	…….
A. **Get a good night's sleep?**	……	…….	……	……
B. **Deal with the usual stresses of daily life?**	…….	…….	…….	…….
C. **Deal with feelings of anxiety or being nervous?**	…….	…….	…….	…….
D. **Deal with feelings of depression or feeling blue?**	…….	…….	…….	…….

Psy
0:0
1:0.25
2:0.5
3: 0.75
4:1
5:1.25
6: 1.5
7: 1.75
8: 2
9: 2.25
10: 2.5
11: 2.75
12: 3

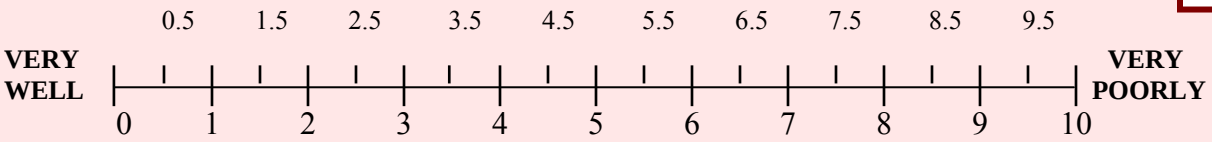
Pain

*** How much PAIN have you had because of your back pain OVER THE PAST WEEK?**
Please put a circle around the number that best indicates your level of pain:



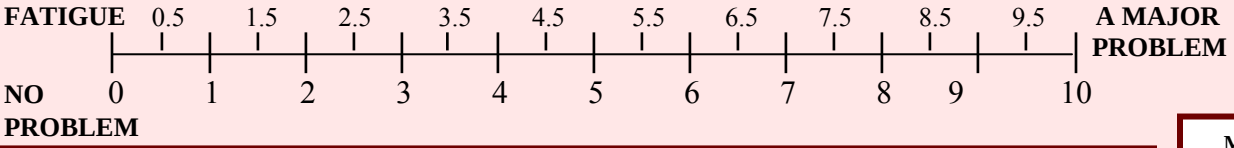
PGA

*** Considering all the ways your back pain may be affecting you OVER THE PAST WEEK**
Please put a circle around the number that best indicates how well you are doing:



Fatigue

*** How much of a problem has UNUSUAL FATIGUE or tiredness been for you OVER THE PAST WEEK? (please put a circle around the number that best indicates your fatigue)**



MS

*** OVER THE LAST WEEK when you awakened in the morning, did you feel stiff?**

YES: □ Please indicate the number of **minutes** ……, or **hours** …… until you are as limber as you will be for the day.
No: □

Date: / / 20 **Patient Name:** ……..

☐ **I consent to my clinical data being used for research/audit** **Signature of the patient:** …….

Low Back Pain Assessment Questionnaire

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There is **no right or wrong answer**. Please answer exactly as **YOU** think or feel. **Thank you**.

1. Where do you have pain? Place a (✓) for all the appropriate sites? **(please circle the appropriate side)**

Neck ☐ Shoulder blade ☐ Middle back ☐ Lower back ☐ Outer side of **Rt. / Lt. / both** hips ☐

2. Where do you feel the pain in your lower back? **(please circle the appropriate side)**

Central LBP Yes ☐ No ☐ Your back pain goes down to your buttocks **(Rt. / Lt. / both)** Yes ☐ No ☐

Both sides of the middle lower back Yes ☐ No ☐ Your low back pain go down to your legs **(Rt. / Lt. / both)** Yes ☐ No ☐

3. **How long have you had your current back pain problem?**

< 6 weeks ☐ 6-12 weeks ☐ > 12 weeks ☐ 3-6 months ☐ over a year ☐

4. **When do you feel your back pain worse?**

In the morning (when you wake up) ☐ Throughout the day ☐ Toward the end of the day ☐

5. **Have you ever had similar attacks of low back pain?**

Never ☐ Once ☐ More than once ☐

6. **Because of your low back pain how many days have you had off work?** **Do not work** ☐

0 days ☐ 1-2 days ☐ 3-7 days ☐ 1-2 weeks ☐ 2-4 weeks ☐

1 month ☐ 2 months ☐ 3-6 months ☐ 6-12 months ☐ over 1 year ☐

7. **What is the nature of your work?**

Office based ☐ Manual Job ☐ Involves lifting heavy objects ☐ Do not work ☐

8. **Do you have fever?** No ☐

Yes ☐ : More in the morning ☐ Throughout the day ☐ Night fever ☐

9. **Over the past year, have you ever had?**

Dizziness / Fainting ☐ Loss of balance ☐ More than one fall ☐ None ☐

10. **How would you rate the effect of your back pain on your sex life?** ☐ Not Applicable

Did not affect ☐ Affected it a little ☐ Affected it to some extent ☐ Affected it to great extent ☐

	Please tick (✓) the appropriate box	Yes	No
N. root Irritation	Do you feel tingling/ numbness/ pins and needles in your toes and/or feet.		
	Do you feel your legs got weaker than before?		
	Do you have problems controlling your water? e.g. passing few drops before you've reached the toilet?		
	Can you lie down flat on your back?		
	Does your back pain affect your sleep?		
Sp. C. Steons	Does your back pain get worse with moving your back e.g. walking, standing		
	Does your back pain get better when you sit down?		
Mec LBP	Do you have weak tummy muscles?		
	Have you ever been diagnosed to be double jointed?		
Systemic Disorder	Have you been diagnosed recently (over the past 3 months) to have anaemia?		
	For men only: Do you have problems with your prostate?		
	For women only: Do you have gynaecological problems?		
	Have you had fracture forearm / hip / or vertebra?		
	Have you ever been diagnosed to have cancer bladder / prostate / bone / lung / or breast? (please circle)		
	Have you lost considerable weight (a stone or more) over the past month?		
	When you wake up, do you feel tired, unable to get out of bed?		
Do you suffer from any other diseases? If Yes what they are:			
What are the medications do you take now? If Yes what they are:			