

Questionnaire survey about the differences in the way individuals interpret and respond to stresses among shooters with and without a history of back pain.

Principal investigator: Zoe Franklin, BSc

Supervisor: Professor Neil Fowler PhD

Dear participant,

We thank you for agreeing to participate in this study. Please be informed, that participation in this study is on a voluntary basis and only involves answering the questions below. The data gathered will be used only by the researchers and solely for the purpose of this study and will not be provided to any other party, company or person. Your identity will be protected and questionnaires analysed in an anonymous fashion.

Please can you complete and return the following questionnaire to zoe.c.franklin@stu.mmu.ac.uk, by completing the questionnaire you are agreeing to the participant statement which can be found on the final page. Your questionnaire will be extracted from your email message and assigned a number which will not be associated in any way to your identity. Or if you would prefer to fill the questionnaire out by hand then please post it back to:

Professor Neil Fowler,
Head of Exercise and Sport Science,
Manchester Metropolitan University,
Crewe Green Road,
Crewe,
Cheshire,
CW1 5DU

The questions should be answered by either typing into the relevant spaces or by clicking on the relevant option to check/cross the box. Select just one box for each question unless otherwise stated.

Many thanks

Zoë Franklin.

Part I: personal characteristics

Please state below:

1. Date of birth (dd/mm/yyyy):	/ /
2. Sex:	
3. Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married / Living together <input type="checkbox"/> Divorced
4. Do you have any children	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Number of years shooting:	
6. Your height in cm:	
7. Your body mass in kg:	
8. Level of shooting experience:	<input type="checkbox"/> Recreational – I shoot for fun / recreation not for competition <input type="checkbox"/> Competitive – I shoot in local and regional competitions <input type="checkbox"/> National – I shoot in national standard competitions <input type="checkbox"/> International – I shoot in international competitions
9. Employment situation:	<input type="checkbox"/> Currently working / studying <input type="checkbox"/> Unemployed – not due to health issues <input type="checkbox"/> Unemployed – due to health issues <input type="checkbox"/> Housewife / House husband <input type="checkbox"/> Retired not due to health reasons <input type="checkbox"/> Retired due to health reasons
10. State Benefits: Are you currently in receipt of any of the following (tick all/any that apply)	<input type="checkbox"/> Statutory sick pay <input type="checkbox"/> Incapacity Benefit / Disability Living allowance etc <input type="checkbox"/> Job Seekers Allowance or other work related benefit <input type="checkbox"/> State Pension

Part II: level of physical activity and injuries

1. I take part in sport activity (please check the box next to the answer that best describes you):

- I do not practice sport regularly
- I practice sport occasionally but not on a regular basis
- I take part in sport at a recreational level and regularly
- I train in one or more sports regularly and I take part in competitions

2. How many hours of sport (including shooting) did you spend on average per week in the last six months (please write down **the number of hours per week**): hours per week

3. Over the past 7 days approximately how long, in total, have you spent in **STRENUOUS** activity. i.e. Activities that have left you heavily out of breath, sweaty and unable to hold a conversation. E.g. running at a fast pace, cycling up a hill etc.

- Less than 15 minutes
- 15-30 minutes
- 30-60 minutes
- More than 60 minutes

4. Over the past 7 days approximately how long, in total, have you spent in **MODERATE** activity. i.e. Activities that have left you a little out of breath, sweaty but able to maintain a conversation. E.g. brisk walking, swimming, heavy gardening etc.

- Less than 15 minutes
- 15-30 minutes
- 30-60 minutes
- More than 60 minutes

5. Over the past 7 days approximately how long, in total, have you spent in **LIGHT** activity. i.e. Activities that do not cause you to be out of breath or sweaty. E.g. Bowls, snooker, walking around the shops etc.

- Less than 30 minutes
- 30-60 minutes
- 1 – 2 hours minutes
- More than 2 hours

6. In the last six months I have injured myself (please check the box next to the answer that best describes you):

- never
- rarely and not seriously (I didn't see a doctor)
- more than rarely but not seriously (I didn't see a doctor)
- seriously (I had to see a doctor or the Accident and Emergency service)
- very seriously (I had to stay in hospital for at least one night)

Part III: questions about general health

This section asks for your views on your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer these questions by “check-marking” your choice. Please select only one choice for each item by filling in the box next to your preferred answer.

1. In general, would you say your health is:

Excellent Very good Good Fair Poor

2. Compared to ONE YEAR AGO, how would you rate your health in general NOW?

- MUCH BETTER** than one year ago.
- Somewhat **BETTER** now than one year ago.
- About the **SAME** as one year ago.
- Somewhat **WORSE** now than one year ago.
- MUCH WORSE** now than one year ago.

3. During the **past 4 weeks**, have you had any of the following problems with your work or other regular activities as a result of your physical health?

	Yes	No
a) Cut down on the amount of time you spent on work or other activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Accomplished less than you would like?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) Were limited in the kind of work or other activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) Had difficulty performing the work or other activities (for example it took extra effort)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

4. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

Not at all Slightly Moderately Quite a bit Extremely

5. How much **bodily pain** have you had during the **past 4 weeks**?

None Very mild Mild Moderate Severe Very severe

6. 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

7. The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

Activities	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a) Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
c) Lifting or carrying groceries?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
d) Climbing several flights of stairs?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
e) Climbing one flight of stairs?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
f) Bending, kneeling or stooping?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
g) Walking more than a mile ?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
h) Walking half a mile ?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
i) Walking quarter of a mile ?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>
j) Bathing or dressing yourself?	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>

8. 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	A good bit of the time	Some of the time	A little of the time	None of the time
a) Did you feel full of enthusiasm?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
b) Have you been a very nervous person?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
c) Have you felt so down in the dumps that nothing could cheer you up?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
d) Have you felt calm and peaceful?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
e) Did you have a lot of energy?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
f) Have you felt downhearted and sad?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
g) Do you feel worn out?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
h) Have you been a happy person?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>
i) Did you feel tired?	All of the time <input type="checkbox"/>	Most of the time <input type="checkbox"/>	A good bit of the time <input type="checkbox"/>	Some of the time <input type="checkbox"/>	A little of the time <input type="checkbox"/>	None of the time <input type="checkbox"/>

9. During the **past 4 weeks**, 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)?

	Yes	No
a) Cut down on the amount of time you spent on work or other activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Accomplished less than you would like?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) Didn't do work or other activities as carefully as usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

10. 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.

11. How TRUE or FALSE is **each** of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to become ill a little easier than other people?	Definitely true <input type="checkbox"/>	Mostly true <input type="checkbox"/>	Don't know <input type="checkbox"/>	Mostly false <input type="checkbox"/>	Definitely false <input type="checkbox"/>
b) I am as healthy as anybody I know?	Definitely true <input type="checkbox"/>	Mostly true <input type="checkbox"/>	Don't know <input type="checkbox"/>	Mostly false <input type="checkbox"/>	Definitely false <input type="checkbox"/>
c) I expect my health to get worse?	Definitely true <input type="checkbox"/>	Mostly true <input type="checkbox"/>	Don't know <input type="checkbox"/>	Mostly false <input type="checkbox"/>	Definitely false <input type="checkbox"/>
d) My health is excellent?	Definitely true <input type="checkbox"/>	Mostly true <input type="checkbox"/>	Don't know <input type="checkbox"/>	Mostly false <input type="checkbox"/>	Definitely false <input type="checkbox"/>

We are aware that emotions play an important part in most illnesses. If we know about these feelings we will be able to help you more. This questionnaire is designed to help us know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response. *[Tick only one box in each section]*

I feel tense or 'wound up':

Most of the time
A lot of the time
Time to time, Occasionally
Not at all

I feel as if I am slowed down:

Nearly all of the time
Very often
Sometimes
Not at all

I still enjoy the things I used to enjoy:

Definitely as much
Not quite so much
Only a little
Hardly at all

I get a sort of frightened feeling like 'butterflies' in the stomach:

Not at all
Occasionally
Quite often
Very often

I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly
Yes, but not too badly
A little, but it doesn't worry me
Not at all

I have lost interest in my appearance:

Definitely
I don't take so much care as I should
I may not take quite as much care
I take just as much care as ever

I can laugh and see the funny side of things:

As much as I always could
Not quite so much now
Definitely not so much now
Not at all...

I feel restless as if I have to be on the move:

Very much indeed
Quite a lot
Not very much
Not at all

Worrying thoughts go through my mind:

A great deal of the time
A lot of the time
From time to time but not too often
Only occasionally

I look forward with enjoyment to things:

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

I feel cheerful:

Not at all
Not often
Sometimes
Most of the time

I get sudden feelings of panic:

Very often indeed
Quite often
Not very often
Not at all

I can sit at ease and feel relaxed:

Definitely
Usually
Not often
Not at all

I can enjoy a good book or radio / TV show:

Often
Sometimes
Not often
Very seldom

Part IV: questions about your feelings

A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right now*, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moderately so	Very much so
I feel calm	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel secure	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am tense	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel strained	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel at ease	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel upset	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am presently worrying over possible misfortunes	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel satisfied	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel frightened	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel comfortable	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel self confident	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel nervous	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am jittery	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel indecisive	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am relaxed	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel content	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am worried	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel confused	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel steady	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel pleasant	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>

A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate *how you generally feel*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	Not at all	Somewhat	Moderately so	Very much so
I feel pleasant	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel nervous and restless	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel satisfied with myself	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I wish I could be as happy as others seem to be	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel like a failure	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel rested	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am calm, cool and collected	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel that difficulties are piling up so that I cannot overcome them	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I worry too much over something that doesn't really matter	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am happy	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I have disturbing thoughts	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I lack self confidence	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel secure	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I make decisions easily	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I feel inadequate	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am confident	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
Some unimportant thoughts run through my mind and bother me	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I take disappointments so keenly that I can't put them out of my mind	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I am a steady person	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>
I get in a state of tension or turmoil as I think over my recent concerns and interests	Not at all <input type="checkbox"/>	Somewhat <input type="checkbox"/>	Moderately so <input type="checkbox"/>	Very much so <input type="checkbox"/>

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

	True	False
I never hesitate to go out of my way to help someone in trouble	<input type="checkbox"/>	<input type="checkbox"/>
I have never intensely disliked anyone	<input type="checkbox"/>	<input type="checkbox"/>
There have been times when I was quite jealous of the good fortune of others	<input type="checkbox"/>	<input type="checkbox"/>
I would never think of letting someone else be punished for my wrong doings	<input type="checkbox"/>	<input type="checkbox"/>
I sometimes feel resentful when I don't get my way	<input type="checkbox"/>	<input type="checkbox"/>
There have been times when I felt like rebelling against people in authority even though I knew they were right	<input type="checkbox"/>	<input type="checkbox"/>
I am always courteous, even to people who are disagreeable	<input type="checkbox"/>	<input type="checkbox"/>
When I don't know something I don't at all mind admitting it	<input type="checkbox"/>	<input type="checkbox"/>
I can remember "playing sick" to get out of something	<input type="checkbox"/>	<input type="checkbox"/>
I am sometimes irritated by people who ask favours of me	<input type="checkbox"/>	<input type="checkbox"/>

Have you suffered any pain to any area of your back (including all areas of the back and neck) in the past six months:

- Yes (please continue onto the following page to the questions about this pain)
 No

If you answered NO to the above question then you have completed all the relevant questions and there is no need to carry on.

Thank you very much for agreeing to take part in the study.

Part V: Back pain

Please complete the following questions if you have experienced pain in any part of your back over the past 6 months.

1. Roughly how long ago did you first experience pain in your back?

- Less than 6 weeks ago
- Between 6 and 12 weeks ago
- Between 3 and 6 months ago
- Between 6 months and 1 year ago
- more than 1 year ago

2. How would you rate your pain on a scale of 0 to 10 at the present time, that is right now, where 0 is 'no pain' and 10 is pain 'as bad as could be'?

No Pain Pain as bad as it could be

- | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. In the past six months, how intense was your worst pain rated on a scale of 0 to 10 where 0 is 'no pain' and 10 is pain 'as bad as could be'?

No Pain Pain as bad as it could be

- | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Roughly how many days in the last **six** months have you experienced pain in your back?

- 0 / no days
- 1-6 days
- 7-14 days
- 15-30 days
- 31 days or more

5. Roughly how many days in the last **six** months have you been kept from your usual activities because of pain?

- 0 / no days
- 1-6 days
- 7-14 days
- 15-30 days
- 31 days or more

When you have back trouble you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back trouble.

As you read the list, think of yourself **today** and **circle true** or **false**, whichever describes you **TODAY**.

1	I stay at home most of the time because of my back pain.	True <input type="checkbox"/>	False <input type="checkbox"/>
2	I change position frequently to try and get myself comfortable.	True <input type="checkbox"/>	False <input type="checkbox"/>
3	I walk more slowly than usual because of my back pain.	True <input type="checkbox"/>	False <input type="checkbox"/>
4	Because of my back, I am not doing any of the jobs that I usually do around the house.	True <input type="checkbox"/>	False <input type="checkbox"/>
5	Because of my back, I use a handrail to get upstairs.	True <input type="checkbox"/>	False <input type="checkbox"/>
6	Because of my back, I lie down to rest more often.	True <input type="checkbox"/>	False <input type="checkbox"/>
7	Because of my back, I have to hold on to something to get out of an easy chair.	True <input type="checkbox"/>	False <input type="checkbox"/>
8	Because of my back, I try to get other people to do things for me.	True <input type="checkbox"/>	False <input type="checkbox"/>
9	I get dressed more slowly than usual because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
10	I only stand up for short periods of time because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
11	Because of my back, I try not to bend or kneel down.	True <input type="checkbox"/>	False <input type="checkbox"/>
12	I find it difficult to get out of a chair because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
13	I am in pain almost all of the time.	True <input type="checkbox"/>	False <input type="checkbox"/>
14	I find it difficult to turn over in bed because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
15	My appetite is not very good because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
16	I have trouble putting on my socks / tights because of the pain in my back pain.	True <input type="checkbox"/>	False <input type="checkbox"/>
17	I only walk short distances because of my back pain.	True <input type="checkbox"/>	False <input type="checkbox"/>
18	I sleep less well because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
19	Because of my back trouble, I get dressed with help from someone else.	True <input type="checkbox"/>	False <input type="checkbox"/>
20	I sit down for most of the day because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>
21	I avoid heavy jobs around the house because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>

22	Because of my back I am more irritable than usual.	True <input type="checkbox"/>	False <input type="checkbox"/>
23	Because of my back I go upstairs more slowly.	True <input type="checkbox"/>	False <input type="checkbox"/>
24	I stay in bed most of the time because of my back.	True <input type="checkbox"/>	False <input type="checkbox"/>

Thank you.

Participant Statement

I have read the participant information sheet for this study and understand what is involved in taking part. Any questions I have about the study, or my participation in it, have been answered to my satisfaction. I understand that I do not have to take part and that I may decide to withdraw from the study at any point without giving a reason. Any concerns I have raised regarding this study have been answered and I understand that any further concerns that arise during the time of the study will be addressed by the investigator. I therefore agree to participate in the study.

It has been made clear to me that, should I feel that my rights are being infringed or that my interests are otherwise being ignored, neglected or denied, I should inform The University Secretary and Clerk to the Board of Governors, Manchester Metropolitan University, Ormond Building, Manchester, M15 6BX. Tel: 0161 247 3400 who will undertake to investigate my complaint.