PATIENT-REPORTED OUTCOME MEASURE (PROM)

PRE-TREATMENT (Baseline)

Patient Reference Number (Clinic use only): ______________

This questionnaire is about THIS PRESENT EPISODE of the COMPLAINT THAT YOU HAVE BEEN REFERRED FOR BY YOUR GP and that you will be TREATED FOR IN THIS CLINIC. It does NOT refer to any previous episodes of a similar complaint that you may have been treated for either in this clinic or elsewhere. Tick ONE box for EACH question unless instructed otherwise.

By completing this form, you consent to your information being used, anonymously and in confidence, to evaluate your treatment for research purposes. It may also be used by your clinician to monitor your progress.

Q1 **PATIENT: START HERE:**
YOUR FIRST NAME AND SURNAME:

☐

Q2 TODAY'S date (dd/mm/yyyy):

☐

Q3 Age (years):

☐

Q4 Are you?

Male ☐ Female ☐

Q5 Where is the pain you are seeking treatment for? (tick as many boxes as apply)

- Back ☐
- Leg ☐
- Neck ☐
- Headache ☐
- Shoulder/arm ☐
- Other ☐

Q6 If your pain is in your back or neck, does it go down into your leg(s) or arm(s)?

Yes ☐ No ☐

Q7 How long has THIS PRESENT EPISODE of your complaint lasted?

- Less than 3 months ☐
- 3-6 months ☐
- 7-12 months ☐
- More than 12 months ☐

Q8 Have you RECENTLY HAD any X-rays, or MRI or CT scan(s), for this PRESENT EPISODE of your complaint?

Yes ☐ No ☐

Q9 Did your GP give you advice on self-management of THIS EPISODE of your complaint (for example, exercise, keeping mobile and as physically active as possible, taking medication (painkillers) if necessary)?

- Yes, ample information ☐
- Yes, some information but would have liked more ☐
- None ☐

Q10 Are you currently waiting for a hospital appointment for ANY of the following for this complaint? (tick as many as apply)

- Physiotherapy ☐
- Orthopaedics ☐
- Rheumatology ☐
- Pain Clinic ☐
- MRI/CT scan ☐

Q11 Are you currently in PAID EMPLOYMENT (includes SELF-EMPLOYED)?

Yes ☐ Go to Q12 and continue No ☐ Go to Q13 overleaf and continue

Q12 How much time have you taken OFF WORK for THIS PRESENT EPISODE of your painful complaint?

- None ☐
- Less than 1 week ☐
- 1-3 weeks ☐
- More than 3 weeks ☐

CONTINUED OVERLEAF

Put a TICK in ONE box for EACH of the following statements that best describes your complaint.

Q13 Over the past few days, on average, how would you rate your pain on a scale where '0' is 'no pain' and '10' is 'worst pain possible'?

	0	1	2	3	4	5	6	7	8	9	10
No pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q14 Over the past few days, on average, how has this complaint interfered with your daily activities (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair, sleeping) on a scale where '0' is 'no interference' and '10' is 'completely unable to carry on with normal daily activities'?

	0	1	2	3	4	5	6	7	8	9	10
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q15 Over the past few days, on average, how has this complaint interfered with your normal social routine including recreational, social and family activities, on a scale where '0' is 'no interference' and '10' is 'completely unable to participate in any social and recreational activity'?

	0	1	2	3	4	5	6	7	8	9	10
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q16 Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where '0' is 'not at all anxious' and '10' is 'extremely anxious'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q17 Over the past few days, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where '0' is 'not at all depressed' and '10' is 'extremely depressed'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q18 Over the past few days, how do you think your work (both inside the home and/or employed work) has affected this complaint, on a scale where '0' is 'make it no worse' and '10 is 'make it very much worse'?

	0	1	2	3	4	5	6	7	8	9	10
Make it no worse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q19 Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own, on a scale where '0' is 'I can control it completely' and '10' is 'I have no control whatsoever'?

	0	1	2	3	4	5	6	7	8	9	10
I have complete control over my pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q20 Finally, over the past few days, how BOTHERSOME or TROUBLESOME has this complaint been?

Not at all ...... ☐ Slightly......... ☐ Moderately... ☐ Very much ... ☐ Extremely..... ☐

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS FORM

Q21 **THE FOLLOWING QUESTIONS TO BE COMPLETED BY TREATING CLINICIAN ONLY.**
(REMINDER: Have you included the Patient Reference Number at the start of this form, and has the patient remembered to date the form at question 2?)

CLINIC/PATHWAY PROVIDER: **Chiropractic** ☐ **Osteopathy** ☐ **Physiotherapy** ☐

CLINICIAN NAME & CLINIC NAME: