### KAPS 2 Month questionnaire





Questionnaire

Follow-up at 2 months

**INSTRUCTIONS FOR THIS QUESTIONNAIRE**

Please can you answer **all** the questions, even if you feel that they do not apply to you. Questions are arranged in sections asking about your aches, pain or stiffness (your pain condition), your feelings about pain, your general health, and general questions about you. Some questions may look like others, but they tell us different things, so please fill them in anyway. 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |

Or indicating Yes or No, again place a **cross** in the box next to your answer

|  |  |
| --- | --- |
| Yes….. | No….. |

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

Here is another example: how to answer a question if you **don’t** have any pain:

|  |  |
| --- | --- |
| Not at all  confident | Completely  confident |

Here is an example of how to answer a question if you are **completely confident**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Now please continue and fill in this questionnaire**

**Section A**

The following questions are about the aches, pain or stiffness you visited your doctor or nurse with approximately **two months ago** (we will refer to this as your **“pain condition”**). According to our records from your response to the first questionnaire **your pain condition was in**…

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | | | | | | | | | |  | | |
|  | | | | | Affix sticker here | | | | |  | | | | | |
|  | | | | |  | | | | | |
|  | | | | |  | | | | | |
|  | | | | |  | | | | | |
| 1) Compared with when you saw your doctor or nurse with this pain condition 2 months ago, how do you feel your **pain is now**? | | | | | | | | | | | | | | |
|  |  | | | | |  | |  | | |  | | |  |
| Completely recovered | | Much better | | Better | | | No change | | Worse | | | Much worse | | |
|  | |  | |  | | |  | |  | | |  | | |

2) Thinking now about your pain condition, please cross one box for each of these questions. In the past 7 days…

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| a) How much did this pain interfere with your enjoyment of life? | | | | |
|  |  |  |  |  |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |
| b) How much did this pain interfere with your ability to concentrate? | | | | |
|  |  |  |  |  |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

Please continue on the next page

Still thinking about the same **pain condition** that you visited your GP or nurse about **two months ago**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2) In the past 7 days… *(Please cross one box for each question)*  c) How much did this pain interfere with your day to day activities? | | | | |
|  |  |  |  |  |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |
| d) How much did this pain interfere with doing tasks away from home (e.g. getting groceries, running errands)? | | | | |
|  |  |  |  |  |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |
| e) How much did this pain interfere with your enjoyment of recreational activities? | | | | |
|  |  |  |  |  |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |
| f) How often did this pain keep you from socialising with others? | | | | |
|  |  |  |  |  |
| Never | Rarely | Sometimes | Often | Always |
|  |  |  |  |  |

3) 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)*

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

4) In the **last 2 weeks**, on **average**, how intense was your **usual** 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)*

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

5) In the **last 2 weeks**, how intense was your **least** painful 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)*

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

6) Overall, **how bothersome has your pain been** in the **last 2 weeks**?   
 *(Please cross one box)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | Slightly | Moderately | Very much | Extremely |
|  |  |  |  |  |

7) Please think about your pain condition over the **last 2 weeks**, as you answer the following questions. *(Please cross one box on each row)*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a) In the last 2 weeks, have you had pain in more than one part of your body? |  |  |
| b) In the last 2 weeks, have you only been able to walk short distances because of your pain? |  |  |
| c) In the last 2 weeks, have you had to dress more slowly than usual because of your pain? |  |  |
| d) In the last 2 weeks, has your most painful area been in your arm (hand, wrist, elbow or shoulder)? |  |  |
| e) Do you feel it is unsafe for a person with a condition like yours to be physically active? |  |  |
| f) Have you had worrying thoughts about your pain a lot of the time in the last 2 weeks? |  |  |
| g) Do you feel that your pain is terrible and it’s never going to get any better? (*yes to both*) |  |  |
| h) In the last 2 weeks, have you stopped enjoying all the things you usually enjoy because of your pain? |  |  |
| i) Have you felt worn out or lacking in energy in the last 2 weeks? |  |  |
| j) Has your pain made you feel down or depressed in the last 2 weeks? |  |  |
| k) In the last 2 weeks have you been bothered a lot by your pain? |  |  |
| l) Do you have any other important health problems? |  |  |

8) Please think about your pain condition over the **last 2 weeks** as you answer the following questions. *(Please cross one box on each row)*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a) Has your pain interfered a lot with your daily activities in the last 2 weeks? |  |  |
| b) In the last 2 weeks, has your pain stopped you from leading a normal life? |  |  |
| c) Do you often feel unsure about how to manage your pain condition? |  |  |
| d) Do you think your pain condition will last a long time? |  |  |
| e) In the last 2 weeks, have you had trouble falling asleep because of your pain? |  |  |
| f) Do you feel your pain is never going to get any better? |  |  |
| g) Have you ever had treatment for this pain condition that did not help? |  |  |
| h) Do you feel that there is nothing you or anyone else can do to help your pain condition? |  |  |
| i) In the last 2 weeks have you had troublesome joint or muscle pain in more than one part of your body? |  |  |
| j) Does your pain stop you from reaching most of your goals in life? |  |  |
| k) Do you often feel unable to cope with your pain? |  |  |
| l) Do you feel you might hurt or harm yourself if you are physically active? |  |  |
| m) Has your pain had a bad or negative effect on any of your close relationships? |  |  |
| n) Do you feel your pain is terrible? |  |  |
| o) Have you had trouble staying asleep because of your pain in the last 2 weeks? |  |  |

**Section B**

The following questions are about the health professionals you have seen and treatments you have received for your **pain condition** (aches, pain or stiffness)in the **last 2 months**.

1) Please write in the table below the **number of times** you have seen each type of health professional in the **last 2 months for your pain condition**. Indicate whether you have seen them at home or at their practice.

|  |  |  |
| --- | --- | --- |
| Health care professional | Home | Practice |
| e.g. General practice nurse | 1 | 3 |
| Doctor (GP) |  |  |
| Practice/District Nurse |  |  |
| Other *(please specify)*....................................................... |  |  |
| Other *(please specify)*....................................................... |  |  |
| Other *(please specify)*....................................................... |  |  |
| Other *(please specify)*....................................................... |  |  |
| Other *(please specify)*....................................................... |  |  |

2) During the **last 2 months**,have you **been to see** any other health care professionals for your pain condition, either in an **NHS service** or **private care**? Further treatments or investigations (e.g. x-rays, surgery) are covered in question 3 on the next page.

|  |  |
| --- | --- |
| Yes………... | *Please complete the table below.* |
| No…………. | *Please turn to* ***question 3*** *on the next page*. |

Please write in the **number of times** you have seen each health care professional in the **last 2 months for your pain condition.**

|  |  |  |
| --- | --- | --- |
| Health care professional | NHS | Private |
| e.g. Physiotherapist | 0 | 3 |
| Consultant/ specialist/ hospital doctor (outpatient clinic) |  |  |
| Physiotherapist |  |  |
| Acupuncturist |  |  |
| Osteopath |  |  |
| Other *(please specify)*........................................................ |  |  |
| Other *(please specify)*........................................................ |  |  |
| Other *(please specify)*........................................................ |  |  |
| Other *(please specify)*......................................................... |  |  |
| Other *(please specify)*......................................................... |  |  |

3) In the **last 2 months**,have you attended an **NHS** or **private hospital** for any investigations or treatments (e.g. x-ray, MRI scan, surgery, epidural injection) related to **your pain condition**? Please ***do not*** include any initial appointments reported in question 1 of this section.

|  |  |
| --- | --- |
| Yes………... | *Please complete the table below to give us some details.* |
| No…………. | *Please proceed to* ***question 4***. |

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment or investigation | Reason for attendance | Number of investigations or treatments in NHS | Number of investigations or treatments in private practice |
| *e.g. x-ray* | *Knee pain* | *1* | *0* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

4) In the **last 2 months**, have you **stayed overnight** as an inpatient in an **NHS or private hospital** for your pain condition?

|  |  |
| --- | --- |
| Yes………... | *Please complete the table below to give us some details.* |
| No…………. | *Please turn to* ***question 5*** *on the next page*. |

|  |  |  |
| --- | --- | --- |
| Reason for inpatient stay | Number of days in  NHS hospital | Number of days in private hospital |
| *e.g. hip joint replacement* | *6* | *0* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

5) In the **last 2 months**, have you personally bought any **over-the-counter medicines** (items that you buy from the chemist / supermarket), **treatments** or **appliances** to help your pain condition?

*These can include painkillers, anti-inflammatory drugs / creams / sprays, massage oils, TENS machine, corsets etc, as well as any herbal or complementary remedies.*

|  |  |
| --- | --- |
| Yes………... | *Please complete the table below to give us some details.* |
| No…………. | *Please move on to* ***section C on the next page***. |

|  |  |
| --- | --- |
| Medicine /Treatment /Appliance | Cost (£) |
| *e.g. paracetamol* | *56p* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Section C**

#### 1) For each of the five sets of statements that follow, please cross the one box that best describes your own health state today.

|  |  |
| --- | --- |
| **Mobility** |  |
| I have no problems walking about........................................... |  |
| I have slight problems walking about...................................... |  |
| I have moderate problems walking about............................... |  |
| I have severe problems walking about.................................... |  |
| I am unable to walk about....................................................... |  |
| **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....................................... |  |
|  |  |
| **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...................................... |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Please **cross the one box** within each section that best describes your own health state **today**. | | |  |
| **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........................................... |  |
|  |  |
| **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..................................... |  |

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2) In general, would you say your health is: *(Please cross one box)* | | | | |
| Excellent | Very Good | Good | Fair | Poor |
|  |  |  |  |  |
| 3) Compared to one year ago, how would you rate your health in general **now**? *(Please cross one box)* | | | | |
| Much better now 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 |
|  |  |  |  |  |

4) During the **past four 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**? *(Please cross one box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Cut down on the **amount of time** you spent on work or other activities |  |  |  |  |  |
| b) **Accomplished less** than you would like |  |  |  |  |  |
| c) Were limited in the **kind** of work or other activities |  |  |  |  |  |
| d) **Had difficulty** performing the work or other activities (for example, it took extra effort) |  |  |  |  |  |

5) During the **past four 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 any emotional problems** (such as feeling depressed or anxious)? *(Please cross one box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Cut down on the **amount of time** you spent on work or other activities |  |  |  |  |  |
| b) **Accomplished less** than you would like |  |  |  |  |  |
| c) Did work or other activities **less carefully than usual** |  |  |  |  |  |

6) 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?   
 *(Please cross one box on each line)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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. |  |  |  |
| b) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, playing golf. |  |  |  |
| c) Lifting or carrying groceries. |  |  |  |
| d) Climbing **several** flights of stairs. |  |  |  |
| e) Climbing **one** flight of stairs. |  |  |  |
| f)Bending, kneeling or stooping. |  |  |  |
| g)Walking **more than a mile**. |  |  |  |
| h) Walking **several hundred yards**. |  |  |  |
| i) Walking **one hundred yards**. |  |  |  |
| j) Bathing or dressing yourself. |  |  |  |

7) In the last week, on how many days did you do vigorous physical activities?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| None | 1 day | 2 days | 3 days | 4 days | 5 days or more |
|  |  |  |  |  |  |

8) How TRUE or FALSE is **each** of the following statements for you?

*(Please cross one box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Definitely true | Mostly true | Don’t know | Mostly false | Definitely false |
| a) I seem to get sick a little easier than other people |  |  |  |  |  |
| b) I am as healthy as anybody I know |  |  |  |  |  |
| c) I expect my health to get worse |  |  |  |  |  |
| d) My health is excellent |  |  |  |  |  |

*Please cross one box for each of the following questions.*

9) During the **past four 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 |
|  |  |  |  |  |

10) How much **bodily** **pain** have you had during the **past four weeks**?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| None | Very mild | Mild | Moderate | Severe | Very severe |
|  |  |  |  |  |  |

*Please cross one box for each of the following questions.*

11) During the past **four 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 |
|  |  |  |  |  |

12) During the **past four 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 |
|  |  |  |  |  |

13) This question is about your **sleep patterns** over the **last four weeks**.   
 (*Please cross one box on each line*)

|  |  |  |  |
| --- | --- | --- | --- |
| **Over the last four weeks did you…** |  |  |  |
|  | Not at all | On some nights | On most nights |
| a) Have trouble falling asleep? |  |  |  |
| b) Wake up several times in the night? |  |  |  |
| c) Have trouble staying asleep? |  |  |  |
| d) Wake up after your usual sleep feeling tired and worn out? |  |  |  |

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

*(Please cross one box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How much time **during the past four weeks**… | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Did you feel full of life? |  |  |  |  |  |
| b) Have you been very nervous? |  |  |  |  |  |
| c) Have you felt so down in the dumps that nothing could cheer you up? |  |  |  |  |  |
| d) Have you felt calm and peaceful? |  |  |  |  |  |
| e) Did you have a lot of energy? |  |  |  |  |  |
| f) Have you felt downhearted and depressed? |  |  |  |  |  |
| g) Did you feel worn out? |  |  |  |  |  |
| h) Have you been happy? |  |  |  |  |  |
| i) Did you feel tired? |  |  |  |  |  |

**END OF QUESTIONNAIRE**

Thank you for taking the time to fill in this questionnaire, your answers will be very useful to us. Please check that you have answered all of the questions.

Please fill in **today’s date**:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Day | |  | Month | |  | Year | | | |
|  | |  |  | |  |  | |  | |
|  |  |  |  |  |  | 2 | 0 |  |  |

If you have any further questions about this questionnaire or the study in general, you can telephone Nicola Halliday on 01782 734987 during office hours. Nicola is the study co-ordinator who is looking after this project.

If you have recently changed your address or telephone number, or are planning to move house in the next month or so, please telephone Nicola Halliday on 01782 734987 with your new details, or enclose them with this questionnaire. This will ensure that the researchers continue to keep your information up to date.

Please return your questionnaire in the FREEPOST envelope provided (no stamp needed).

**Thank you for your help with this research project.**