OUTTEN CHIROPRACTIC & CARY SPINAL DECOMPRESSION CENTER
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Bournemouth Back Questionnaire©

Patient Name: ____

Date: ____

Signature:____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and CIRCLE the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

0=No pain 1 2 3 4 5 6 7 8 9 10=Worst Pain Possible

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

0=No interference 1 2 3 4 5 6 7 8 9 10= Unable to carry out activity

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

0=No interference 1 2 3 4 5 6 7 8 9 10= Unable to carry out activity

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0=Not anxious 1 2 3 4 5 6 7 8 9 10=extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

0=Not depressed 1 2 3 4 5 6 7 8 9 10=extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

q 0=Have made it no worse 1 2 3 4 5 6 7 8 9 10=Has made it much worse

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

0=Complete control 1 2 3 4 5 6 7 8 9 10=No control whatsoever

Comments:____

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