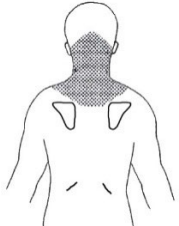


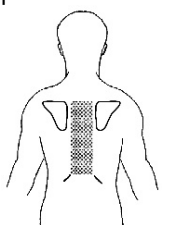


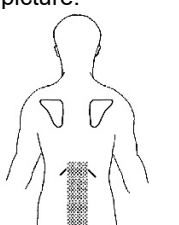




Use **only one cross** to answer each question (except question 5, where several answers are possible). If none of the answers are suitable, place your cross by the answer that is best suited.

To the girls: This questionnaire only asks about back pain that does not occur in connection with your menstruation (period).

Age (in years): \_\_\_\_\_ Gender:  Boy  Girl  Divers

<p><b>1. Neck</b> The neck is shown in the picture:</p>  <p>Person seen from behind</p>	<p>1a. Have you had pain in the neck?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p>	<p>The faces below show how much something can hurt. The pain ranges from 'no pain' to 'a lot of pain'. Put a cross (X) on the face which shows how much pain you have had in the neck when it was worst.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
	<p>1b. Have you had pain in the neck <b>in the last week</b>?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while (several times a week) <input type="checkbox"/> Every day</p>	<p>Put a cross (X) on the face which shows how much pain you have had in the neck when it was worst <b>last week</b>.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
<p><b>2. Middle of the back</b> The middle of the back is shown in the picture:</p>  <p>Person seen from behind</p>	<p>2a. Have you had pain in the middle of the back?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p>	<p>Put a cross (X) on the face which shows how much pain you have had in the middle of the back when it was worst.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
	<p>2b. Have you had pain in the middle of the back <b>in the last week</b>?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while (several times a week) <input type="checkbox"/> Every day</p>	<p>Put a cross (X) on the face which shows how much pain you have had in the middle of the back when it was worst <b>last week</b>.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
<p><b>3. Lower back</b> The lower back is shown in the picture:</p>  <p>Person seen from behind</p>	<p>3a. Have you had pain in the lower back?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p>	<p>Put a cross (X) on the face which shows how much pain you have had in the lower back when it was worst.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
	<p>3b. Have you had pain in the lower back <b>in the last week</b>?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while (several times a week) <input type="checkbox"/> Every day</p>	<p>Put a cross (X) on the face which shows how much pain you have had in the lower back when it was worst <b>last week</b>.</p> <p>No pain <span style="float: right;">A lot of pain</span></p> 
<p><b>4. School, Sports, Treatment</b></p>	<p>Have you stayed home from school because of neck or back pain?  <input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p> <p>Has neck or back pain sometimes stopped you from doing sports?  <input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p> <p>Have you been to a doctor, chiropractor or physiotherapist because of neck or back pain?  <input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while <input type="checkbox"/> Often</p>	
<p><b>5. Other pain</b></p>	<p>Have you had pain in the following areas of your body in the last week (multiple answers possible)?  <input type="checkbox"/> No  <input type="checkbox"/> Yes, headache <input type="checkbox"/> Yes, belly pain (apart from menstrual problems)  <input type="checkbox"/> Yes, arm pain (shoulder, elbow, hand) <input type="checkbox"/> Yes, leg pain (thigh, knee, foot/ankle)  <input type="checkbox"/> Yes, pain in another place: _____ (indicate the place where you had pain)</p>	
<p><b>6. Sleep</b></p>	<p>Did you have trouble falling asleep last week or did you wake up frequently during the night?  <input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while (several times a week) <input type="checkbox"/> Every night</p> <p>Have you felt sleepy during the day in the last week?  <input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> Once in a while (several times a week) <input type="checkbox"/> Every day</p>	
<p><b>7. General health</b></p>	<p>How would you describe your health in general?  <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Do you think your health would be better without neck or back pain?  <input type="checkbox"/> No, because I don't have any neck/back pain  <input type="checkbox"/> No, because the neck/back pain has no effect on my health  <input type="checkbox"/> Yes, without neck/back pain my health would be much better  <input type="checkbox"/> Yes, without neck/back pain my health would be a little better</p>	