***Effectiveness of conservative multimodal physiotherapy in chronic whiplash-associated disorders in individuals with or without posttraumatic stress symptoms: A pilot series of Single Case Experimental Designs (SCEDs)***

**Baseline Diary**

**Please answer the questions below at around the same time of day, each day. Please answer every question.**

# Day 1

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

# Day 2

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 3

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 4

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 5

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 6

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 7

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 8

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 9

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 10

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 11

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Section 2 – Neck Disability Index (NDI)

This questionnaire has been designed to give us information as to **how your neck pain has affected your ability to manage in everyday life. Please answer every section** and mark in each section **only the one box that applies to you.** We realise you may consider that two or more statements in any one section relate to you, but please just mark **the box that most closely describes your problem right now.**

|  |  |  |
| --- | --- | --- |
| * 1. **PAIN INTENSITY** * I have no pain at the moment. * The pain is mild at the moment. * The pain comes and goes and is moderate. * The pain is moderate and does not vary much. * The pain is severe but comes and goes. * The pain is severe and does not vary much. | * 1. **READING**       + - I can read as much as I want to with no pain in my neck.        - I can read as much as I want with slight pain in my neck.        - I can read as much as I want with moderate pain in my neck.        - I cannot read as much as I want because of moderate pain in my neck.        - I cannot read as much as I want because of severe pain in my neck.        - I cannot read at all. | * 1. **DRIVING** (omit this question if you never drive a car when in good health)   + I can drive my car without neck pain.   + I can drive my car as long as I want with slight pain in my neck.   + I can drive my car as long as I want with moderate pain in my neck.   + I cannot drive my car as long as I want because of moderate pain in my neck.   + I can hardly drive my car at all because of severe pain in my neck.   + I cannot drive my car at all. |
| * 1. **HEADACHE**   + I have no headaches at all.   + I have slight headaches which come infrequently.   + I have moderate headaches which come infrequently.   + I have moderate headaches which come frequently.   + I have severe headaches which come frequently.   + I have headaches almost all the time. |
| * 1. **PERSONAL CARE**      + I can look after myself without causing extra pain.      + I can look after myself normally but it causes extra pain.      + It is painful to look after myself and I am slow and careful.      + I need some help, but manage most of my personal care.      + I need help every day in most aspects of self-care.      + I do not get dressed, I wash with difficulty and stay in bed. | * 1. **NECK PAIN AND SLEEPING**   + I have no trouble sleeping.   + My sleep is slightly disturbed (less than 1 hour sleepless).   + My sleep is mildly disturbed (1-2 hours sleepless).   + My sleep is moderately disturbed (2-3 hours sleepless).   + My sleep is greatly disturbed (3-5 hours sleepless).   + My sleep is completely disturbed (5-7 hours sleepless). |
| * 1. **CONCENTRATION** * I can concentrate fully when I want to with no difficulty. * I can concentrate fully when I want to with slight difficulty. * I have a fair degree of difficulty concentrating when I want to. * I have a lot of difficulty concentrating when I want to. * I have a great deal of difficulty concentrating when I want to. * I cannot concentrate at all. |
| * 1. **LIFTING**      + - I can lift heavy objects without extra pain        - I can lift heavy objects but it causes extra pain        - Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example on a table.        - Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.        - I can lift very light weights.        - I cannot lift or carry anything at all. | * 1. **RECREATION**   + I am able to engage in all recreational activities with no pain in my neck at all.   + I am able to engage in all recreational activities with some pain in my neck.   + I am able to engage in most, but not all recreational activities because of pain in my neck.   + I am able to engage in a few of my usual recreational activities because of pain in my neck.   + I can hardly do any recreational activities because of pain in my neck.   + I cannot do any recreational activities at all. |
| * 1. **WORK** * I can do as much work as I want to. * I can only do my usual work, but no more. * I can do most of my usual work, but no more. * I cannot do my usual work. * I can hardly do any work at all. * I cannot do any work at all. |

|  |  |  |
| --- | --- | --- |
| **Section 3 – DASS-21** | | |
| Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past 2 weeks*. There are no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows:  Did not apply to me at all  Applied to me to some degree, or some of the time  Applied to me to a considerable degree, or a good part of time  Applied to me very much, or most of the time | | |
| 1 | I found it hard to wind down | 0 1 2 3 |
| 2 | I was aware of dryness of my mouth | 0 1 2 3 |
| 3 | I couldn't seem to experience any positive feeling at all | 0 1 2 3 |
| 4 | I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 1 2 3 |
| 5 | I found it difficult to work up the initiative to do things | 0 1 2 3 |
| 6 | I tended to over-react to situations | 0 1 2 3 |
| 7 | I had a feeling of trembling (e.g., in the hands) | 0 1 2 3 |
| 8 | I felt that I was using a lot of nervous energy | 0 1 2 3 |
| 9 | I was worried about situations in which I might panic and make a fool of myself | 0 1 2 3 |
| 10 | I felt that I had nothing to look forward to | 0 1 2 3 |
| 11 | I found myself getting agitated | 0 1 2 3 |
| 12 | I found it difficult to relax | 0 1 2 3 |
| 13 | I felt down-hearted and blue | 0 1 2 3 |
| 14 | I was intolerant of anything that kept me from getting on with what I was doing | 0 1 2 3 |
| 15 | I felt I was close to panic | 0 1 2 3 |
| 16 | I was unable to become enthusiastic about anything | 0 1 2 3 |
| 17 | I felt I wasn't worth much as a person | 0 1 2 3 |
| 18 | I felt that I was rather touchy | 0 1 2 3 |
| 19 | I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat | 0 1 2 3 |
| 20 | I felt scared without any good reason | 0 1 2 3 |
| 21 | I felt that life was meaningless | 0 1 2 3 |
| 3.1 Total Score: | |  |

# Section 4 – Expectations for Recovery

**“Do you think that your injury will…**

**1** ❑ Get better soon

**2** ❑ Get better slowly

**3** ❑ Never get better

**4** ❑ Don’t know

# Section 5 - PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RATING** | **0** | **1** | **2** | **3** | **4** |
| **MEANING** | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |

**When I’m in pain …**

|  |  |  |
| --- | --- | --- |
| **Number** | **Statement** | **Rating** |
| 1 | I worry all the time about whether the pain will end. |  |
| 2 | I feel I can’t go on. |  |
| 3 | It’s terrible and I think it’s never going to get any better |  |
| 4 | It’s awful and I feel that it overwhelms me. |  |
| 5 | I feel I can’t stand it anymore |  |
| 6 | I become afraid that the pain will get worse. |  |
| 7 | I keep thinking of other painful events |  |
| 8 | I anxiously want the pain to go away |  |
| 9 | I can’t seem to keep it out of my mind |  |
| 10 | I keep thinking about how much it hurts. |  |
| 11 | I keep thinking about how badly I want the pain to stop |  |
| 12 | There’s nothing I can do to reduce the intensity of the pain |  |
| 13 | I wonder whether something serious may happen. |  |

# Section 6 – PSEQ

Please rate how confident you are that you can do the following things at present, despite the pain.

To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident. For example



Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

1. **I can enjoy things, despite the pain.**



1. **I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.**



1. **I can socialise with my friends or family members as often as I used to do, despite the pain.**



1. **I can cope with my pain in most situations.**



1. **I can do some form of work, despite the pain. (“work” includes housework, paid and unpaid work).**



1. **I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.**



1. **I can cope with my pain without medication.**



1. **I can still accomplish most of my goals in life, despite the pain.**



1. **I can live a normal lifestyle, despite the pain.**



1. **I can gradually become more active, despite the pain.**



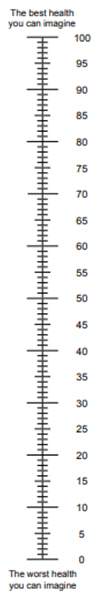
# Section 7 – EQ-5D-5L Health Questionnaire

**Under each heading, please tick the ONE box that best describes your health TODAY.**

1. **Mobility**

* I have no problems in walking about
* I have slight problems in walking about
* I have moderate problems in walking about
* I have severe problems in walking about
* I am unable to walk about

1. **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

1. **Usual activities (e.g. work, study, housework, family or leisure activities)**

* I haver 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

1. **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

1. **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
* We would like to know how good or bad your health is TODAY
* This scale is numbered from 0 to 100
* 100 means the best health you can imagine.

0 means the worst health you can imagine

* Mark an X on the scale to indicate how your health is TODAY
* Now, please write the number you marked on the scale in the box below
* Your Health TODAY =

**Trial phase diary**

# Day 1

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours? On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 2

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 3

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 4

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 5

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 6

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 7

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 8

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 9

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 10

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 11

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 12

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 13

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 14

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please Complete Sections 2 – 8 on following pages today.**

# Section 2 – Neck Disability Index (NDI)

This questionnaire has been designed to give us information as to **how your neck pain has affected your ability to manage in everyday life. Please answer every section** and mark in each section **only the one box that applies to you.** We realise you may consider that two or more statements in any one section relate to you, but please just mark **the box that most closely describes your problem right now.**

|  |  |  |
| --- | --- | --- |
| * 1. **PAIN INTENSITY** * I have no pain at the moment. * The pain is mild at the moment. * The pain comes and goes and is moderate. * The pain is moderate and does not vary much. * The pain is severe but comes and goes. * The pain is severe and does not vary much. | * 1. **READING**       + - I can read as much as I want to with no pain in my neck.        - I can read as much as I want with slight pain in my neck.        - I can read as much as I want with moderate pain in my neck.        - I cannot read as much as I want because of moderate pain in my neck.        - I cannot read as much as I want because of severe pain in my neck.        - I cannot read at all. | * 1. **DRIVING** (omit this question if you never drive a car when in good health)   + I can drive my car without neck pain.   + I can drive my car as long as I want with slight pain in my neck.   + I can drive my car as long as I want with moderate pain in my neck.   + I cannot drive my car as long as I want because of moderate pain in my neck.   + I can hardly drive my car at all because of severe pain in my neck.   + I cannot drive my car at all. |
| * 1. **HEADACHE**   + I have no headaches at all.   + I have slight headaches which come infrequently.   + I have moderate headaches which come infrequently.   + I have moderate headaches which come frequently.   + I have severe headaches which come frequently.   + I have headaches almost all the time. |
| * 1. **PERSONAL CARE**      + I can look after myself without causing extra pain.      + I can look after myself normally but it causes extra pain.      + It is painful to look after myself and I am slow and careful.      + I need some help, but manage most of my personal care.      + I need help every day in most aspects of self-care.      + I do not get dressed, I wash with difficulty and stay in bed. | * 1. **NECK PAIN AND SLEEPING**   + I have no trouble sleeping.   + My sleep is slightly disturbed (less than 1 hour sleepless).   + My sleep is mildly disturbed (1-2 hours sleepless).   + My sleep is moderately disturbed (2-3 hours sleepless).   + My sleep is greatly disturbed (3-5 hours sleepless).   + My sleep is completely disturbed (5-7 hours sleepless). |
| * 1. **CONCENTRATION** * I can concentrate fully when I want to with no difficulty. * I can concentrate fully when I want to with slight difficulty. * I have a fair degree of difficulty concentrating when I want to. * I have a lot of difficulty concentrating when I want to. * I have a great deal of difficulty concentrating when I want to. * I cannot concentrate at all. |
| * 1. **LIFTING**      + - I can lift heavy objects without extra pain        - I can lift heavy objects but it causes extra pain        - Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example on a table.        - Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.        - I can lift very light weights.        - I cannot lift or carry anything at all. | * 1. **RECREATION**   + I am able to engage in all recreational activities with no pain in my neck at all.   + I am able to engage in all recreational activities with some pain in my neck.   + I am able to engage in most, but not all recreational activities because of pain in my neck.   + I am able to engage in a few of my usual recreational activities because of pain in my neck.   + I can hardly do any recreational activities because of pain in my neck.   + I cannot do any recreational activities at all. |
| * 1. **WORK** * I can do as much work as I want to. * I can only do my usual work, but no more. * I can do most of my usual work, but no more. * I cannot do my usual work. * I can hardly do any work at all. * I cannot do any work at all. |

|  |  |  |
| --- | --- | --- |
| **Section 3 – DASS-21** | | |
| Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past 2 weeks*. There are no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows:  0 Did not apply to me at all  1 Applied to me to some degree, or some of the time  2 Applied to me to a considerable degree, or a good part of time  3 Applied to me very much, or most of the time | | |
| 1 | I found it hard to wind down | 0 1 2 3 |
| 2 | I was aware of dryness of my mouth | 0 1 2 3 |
| 3 | I couldn't seem to experience any positive feeling at all | 0 1 2 3 |
| 4 | I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 1 2 3 |
| 5 | I found it difficult to work up the initiative to do things | 0 1 2 3 |
| 6 | I tended to over-react to situations | 0 1 2 3 |
| 7 | I had a feeling of trembling (e.g., in the hands) | 0 1 2 3 |
| 8 | I felt that I was using a lot of nervous energy | 0 1 2 3 |
| 9 | I was worried about situations in which I might panic and make a fool of myself | 0 1 2 3 |
| 10 | I felt that I had nothing to look forward to | 0 1 2 3 |
| 11 | I found myself getting agitated | 0 1 2 3 |
| 12 | I found it difficult to relax | 0 1 2 3 |
| 13 | I felt down-hearted and blue | 0 1 2 3 |
| 14 | I was intolerant of anything that kept me from getting on with what I was doing | 0 1 2 3 |
| 15 | I felt I was close to panic | 0 1 2 3 |
| 16 | I was unable to become enthusiastic about anything | 0 1 2 3 |
| 17 | I felt I wasn't worth much as a person | 0 1 2 3 |
| 18 | I felt that I was rather touchy | 0 1 2 3 |
| 19 | I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat | 0 1 2 3 |
| 20 | I felt scared without any good reason | 0 1 2 3 |
| 21 | I felt that life was meaningless | 0 1 2 3 |
|  | 3.1 Total |  |

# Section 4 - PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RATING** | **0** | **1** | **2** | **3** | **4** |
| **MEANING** | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |

**When I’m in pain …**

|  |  |  |
| --- | --- | --- |
| **Number** | **Statement** | **Rating** |
| 1 | I worry all the time about whether the pain will end. |  |
| 2 | I feel I can’t go on. |  |
| 3 | It’s terrible and I think it’s never going to get any better |  |
| 4 | It’s awful and I feel that it overwhelms me. |  |
| 5 | I feel I can’t stand it anymore |  |
| 6 | I become afraid that the pain will get worse. |  |
| 7 | I keep thinking of other painful events |  |
| 8 | I anxiously want the pain to go away |  |
| 9 | I can’t seem to keep it out of my mind |  |
| 10 | I keep thinking about how much it hurts. |  |
| 11 | I keep thinking about how badly I want the pain to stop |  |
| 12 | There’s nothing I can do to reduce the intensity of the pain |  |
| 13 | I wonder whether something serious may happen. |  |

# SECTION 6 – Patient Global Impression of Change

**How would you describe your whiplash problem now, compared to how it was at the time you started this trial?**

**1** ❑ Very much improved

**2** ❑ Much improved

**3** ❑ Minimally improved

**4** ❑ No change

**5** ❑ Worse

**6** ❑ Much Worse

**7** ❑ Very much Worse

# Section 7 – PSEQ

Please rate how confident you are that you can do the following things at present, despite the pain.

To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident. For example



Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

1. **I can enjoy things, despite the pain.**



1. **I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.**



1. **I can socialise with my friends or family members as often as I used to do, despite the pain.**



1. **I can cope with my pain in most situations.**



1. **I can do some form of work, despite the pain. (“work” includes housework, paid and unpaid work).**



1. **I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.**



1. **I can cope with my pain without medication.**



1. **I can still accomplish most of my goals in life, despite the pain.**



1. **I can live a normal lifestyle, despite the pain.**



1. **I can gradually become more active, despite the pain.**



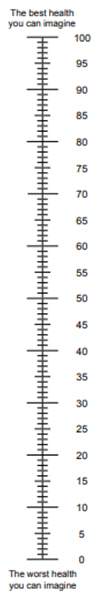
# Section 8 – EQ-5D-5L Health Questionnaire

**Under each heading, please tick the ONE box that best describes your health TODAY.**

1. **Mobility**

* I have no problems in walking about
* I have slight problems in walking about
* I have moderate problems in walking about
* I have severe problems in walking about
* I am unable to walk about

1. **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

1. **Usual activities (e.g. work, study, housework, family or leisure activities)**

* I haver 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

1. **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

1. **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
* We would like to know how good or bad your health is TODAY
* This scale is numbered from 0 to 100
* 100 means the best health you can imagine.

0 means the worst health you can imagine

* Mark an X on the scale to indicate how your health is TODAY
* Now, please write the number you marked on the scale in the box below
* Your Health TODAY =

9. Have you experienced any adverse effects of the study treatment over the last two weeks? Yes/No

10. If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

# Day 15

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 16

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 17

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 18

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 19

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 20

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 21

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 22

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 23

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 24

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 25

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 26

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 27

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 28

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please complete sections 2 – 8 on the following pages today.**

# Section 2 – Neck Disability Index (NDI)

This questionnaire has been designed to give us information as to **how your neck pain has affected your ability to manage in everyday life. Please answer every section** and mark in each section **only the one box that applies to you.** We realise you may consider that two or more statements in any one section relate to you, but please just mark **the box that most closely describes your problem right now.**

|  |  |  |
| --- | --- | --- |
| * 1. **PAIN INTENSITY** * I have no pain at the moment. * The pain is mild at the moment. * The pain comes and goes and is moderate. * The pain is moderate and does not vary much. * The pain is severe but comes and goes. * The pain is severe and does not vary much. | * 1. **READING**       + - I can read as much as I want to with no pain in my neck.        - I can read as much as I want with slight pain in my neck.        - I can read as much as I want with moderate pain in my neck.        - I cannot read as much as I want because of moderate pain in my neck.        - I cannot read as much as I want because of severe pain in my neck.        - I cannot read at all. | * 1. **DRIVING** (omit this question if you never drive a car when in good health)   + I can drive my car without neck pain.   + I can drive my car as long as I want with slight pain in my neck.   + I can drive my car as long as I want with moderate pain in my neck.   + I cannot drive my car as long as I want because of moderate pain in my neck.   + I can hardly drive my car at all because of severe pain in my neck.   + I cannot drive my car at all. |
| * 1. **HEADACHE**   + I have no headaches at all.   + I have slight headaches which come infrequently.   + I have moderate headaches which come infrequently.   + I have moderate headaches which come frequently.   + I have severe headaches which come frequently.   + I have headaches almost all the time. |
| * 1. **PERSONAL CARE**      + I can look after myself without causing extra pain.      + I can look after myself normally but it causes extra pain.      + It is painful to look after myself and I am slow and careful.      + I need some help, but manage most of my personal care.      + I need help every day in most aspects of self-care.      + I do not get dressed, I wash with difficulty and stay in bed. | * 1. **NECK PAIN AND SLEEPING**   + I have no trouble sleeping.   + My sleep is slightly disturbed (less than 1 hour sleepless).   + My sleep is mildly disturbed (1-2 hours sleepless).   + My sleep is moderately disturbed (2-3 hours sleepless).   + My sleep is greatly disturbed (3-5 hours sleepless).   + My sleep is completely disturbed (5-7 hours sleepless). |
| * 1. **CONCENTRATION** * I can concentrate fully when I want to with no difficulty. * I can concentrate fully when I want to with slight difficulty. * I have a fair degree of difficulty concentrating when I want to. * I have a lot of difficulty concentrating when I want to. * I have a great deal of difficulty concentrating when I want to. * I cannot concentrate at all. |
| * 1. **LIFTING**      + - I can lift heavy objects without extra pain        - I can lift heavy objects but it causes extra pain        - Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example on a table.        - Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.        - I can lift very light weights.        - I cannot lift or carry anything at all. | * 1. **RECREATION**   + I am able to engage in all recreational activities with no pain in my neck at all.   + I am able to engage in all recreational activities with some pain in my neck.   + I am able to engage in most, but not all recreational activities because of pain in my neck.   + I am able to engage in a few of my usual recreational activities because of pain in my neck.   + I can hardly do any recreational activities because of pain in my neck.   + I cannot do any recreational activities at all. |
| * 1. **WORK** * I can do as much work as I want to. * I can only do my usual work, but no more. * I can do most of my usual work, but no more. * I cannot do my usual work. * I can hardly do any work at all. * I cannot do any work at all. |

|  |  |  |
| --- | --- | --- |
| **Section 3 – DASS-21** | | |
| Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past 2 weeks*. There are no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows:  0 Did not apply to me at all  1 Applied to me to some degree, or some of the time  2 Applied to me to a considerable degree, or a good part of time  3 Applied to me very much, or most of the time | | |
| 1 | I found it hard to wind down | 0 1 2 3 |
| 2 | I was aware of dryness of my mouth | 0 1 2 3 |
| 3 | I couldn't seem to experience any positive feeling at all | 0 1 2 3 |
| 4 | I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 1 2 3 |
| 5 | I found it difficult to work up the initiative to do things | 0 1 2 3 |
| 6 | I tended to over-react to situations | 0 1 2 3 |
| 7 | I had a feeling of trembling (e.g., in the hands) | 0 1 2 3 |
| 8 | I felt that I was using a lot of nervous energy | 0 1 2 3 |
| 9 | I was worried about situations in which I might panic and make a fool of myself | 0 1 2 3 |
| 10 | I felt that I had nothing to look forward to | 0 1 2 3 |
| 11 | I found myself getting agitated | 0 1 2 3 |
| 12 | I found it difficult to relax | 0 1 2 3 |
| 13 | I felt down-hearted and blue | 0 1 2 3 |
| 14 | I was intolerant of anything that kept me from getting on with what I was doing | 0 1 2 3 |
| 15 | I felt I was close to panic | 0 1 2 3 |
| 16 | I was unable to become enthusiastic about anything | 0 1 2 3 |
| 17 | I felt I wasn't worth much as a person | 0 1 2 3 |
| 18 | I felt that I was rather touchy | 0 1 2 3 |
| 19 | I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat | 0 1 2 3 |
| 20 | I felt scared without any good reason | 0 1 2 3 |
| 21 | I felt that life was meaningless | 0 1 2 3 |
|  | 3.1 Total |  |

# Section 5 - PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RATING** | **0** | **1** | **2** | **3** | **4** |
| **MEANING** | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |

**When I’m in pain …**

|  |  |  |
| --- | --- | --- |
| **Number** | **Statement** | **Rating** |
| 1 | I worry all the time about whether the pain will end. |  |
| 2 | I feel I can’t go on. |  |
| 3 | It’s terrible and I think it’s never going to get any better |  |
| 4 | It’s awful and I feel that it overwhelms me. |  |
| 5 | I feel I can’t stand it anymore |  |
| 6 | I become afraid that the pain will get worse. |  |
| 7 | I keep thinking of other painful events |  |
| 8 | I anxiously want the pain to go away |  |
| 9 | I can’t seem to keep it out of my mind |  |
| 10 | I keep thinking about how much it hurts. |  |
| 11 | I keep thinking about how badly I want the pain to stop |  |
| 12 | There’s nothing I can do to reduce the intensity of the pain |  |
| 13 | I wonder whether something serious may happen. |  |

# SECTION 6 – Patient Global Impression of Change

**How would you describe your whiplash problem now, compared to how it was at the time you started this trial?**

**1** ❑ Very much improved

**2** ❑ Much improved

**3** ❑ Minimally improved

**4** ❑ No change

**5** ❑ Worse

**6** ❑ Much Worse

**7** ❑ Very much Worse

# Section 7 – PSEQ

Please rate how confident you are that you can do the following things at present, despite the pain.

To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident. For example



Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

1. **I can enjoy things, despite the pain.**



1. **I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.**



1. **I can socialise with my friends or family members as often as I used to do, despite the pain.**



1. **I can cope with my pain in most situations.**



1. **I can do some form of work, despite the pain. (“work” includes housework, paid and unpaid work).**



1. **I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.**



1. **I can cope with my pain without medication.**



1. **I can still accomplish most of my goals in life, despite the pain.**



1. **I can live a normal lifestyle, despite the pain.**



1. **I can gradually become more active, despite the pain.**



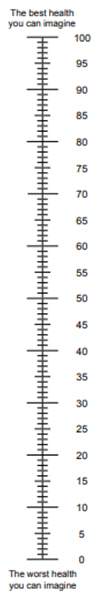
# Section 8 – EQ-5D-5L Health Questionnaire

**Under each heading, please tick the ONE box that best describes your health TODAY.**

1. **Mobility**

* I have no problems in walking about
* I have slight problems in walking about
* I have moderate problems in walking about
* I have severe problems in walking about
* I am unable to walk about

1. **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

1. **Usual activities (e.g. work, study, housework, family or leisure activities)**

* I haver 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

1. **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

1. **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
* We would like to know how good or bad your health is TODAY
* This scale is numbered from 0 to 100
* 100 means the best health you can imagine.

0 means the worst health you can imagine

* Mark an X on the scale to indicate how your health is TODAY
* Now, please write the number you marked on the scale in the box below
* Your Health TODAY =

9. Have you experienced any adverse effects of the study treatment over the last two weeks? Yes/No

10. If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

**Follow up**

**Please start this journal entry at the beginning of the 3rd week after completing your treatment, as to complete by the end of the 4th week for your further follow up.**

# Day 1

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours? On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

# Day 2

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 3

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 4

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 5

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 6

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Day 7

1. Date (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was your pain in the last 24 hours?

On the scale below please estimate the average *intensity of your neck pain* **in the last 24 hours**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | 10 | |
| No Pain | | | | | | | | | |  | | Worst possible pain |

3. How confident are you in your ability to perform your daily tasks in the presence of your neck pain or disability? Please circle the best answer.

1 *not at all confident 2 a little confident 3 moderately confident*

*4 very confident* 5 *extremely confident 6 Not applicable*

4. Other treatments for whiplash (if any): please record what type of treatment e.g. Massage, name of medication, dose and time/s taken

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment type | | | |
| 4.1 | | | |
| 4.2 | | | |
| 4.3 | | | |
| Medication name | Dose | Time Taken | Time Taken |
| 4.1 | 4.4 | 4.7 | 4.10 |
| 4.2 | 4.5 | 4.8 | 4.11 |
| 4.3 | 4.6 | 4.9 | 4.12 |

**Comments:**

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**Thank you for answering these questions.**

**Please return this diary to:**

**RECOVER Injury Research Centre**

**The University of Queensland**

**Level 7, UQ Oral Health Centre**

**Herston, QLD 4006, Australia**

**Or email to: recover**[**@uq.edu.au**](mailto:pregabalin@uq.edu.au)