# Extended Aberdeen Spine Pain Scale

**SECTION A** **Please answer the following questions**

1. In the last two weeks, how many days did you suffer pain in the neck, back or limbs? *(Please tick one box)*

   None at all ☐
   Between 1 and 5 days ☐
   Between 6 and 10 days ☐
   For more than 10 days ☐

2. On the worst day during the last two weeks, how many painkilling tablets did you take? *(Please tick one box)*

   None at all ☐
   Less than four tablets ☐
   Between 4 and 8 tablets ☐
   Between 9 and 12 tablets ☐
   More than 12 tablets ☐

3. Is the pain made worse by any of the following?
   *(Please tick all boxes that apply to you)*

   a) Coughing ☐
   b) Sneezing ☐
   c) Sitting ☐
   d) Bending ☐

   If you have neck pain
   f) Tilting head back ☐

   If you have upper back pain
   g) Twisting trunk ☐
   h) Taking a deep breath ☐

   If you have lower back pain
   i) Standing ☐
   j) Walking ☐

4. On the worst night during the last two weeks, how badly was your sleep affected by the pain? *(Please tick one box)*

   Not affected at all ☐
   I didn't lose any sleep but needed tablets ☐
   It prevented me from sleeping, but I slept more than 4 hours ☐
   I only had 2-4 hours sleep ☐
   I had less than 2 hours sleep ☐

5. In the last two weeks, did pain prevent you from carrying out your work/ housework and other daily activities? *(Please tick one box)*

   No, not at all ☐
   I could continue with my work, but my work suffered ☐
   Yes, for one day ☐
   Yes, for 2-6 days ☐
   Yes, for more than 7 days ☐

6. In the last two weeks, for how many days have you had to stay in bed because of the pain? *(Please tick one box)*

   None at all ☐
   Between 1 and 5 days ☐
   Between 6 and 10 days ☐
   For more than 10 days ☐

7. In the last two weeks, has your sex life been affected by your pain? *(Please tick one box)*

   Not affected by the pain ☐
   Mildly affected by the pain ☐
   Moderately affected by the pain ☐
   Pain prevents any sex life at all ☐
   Does not apply ☐

8. In the last two weeks, have your leisure activities been affected by your pain (including sports, hobbies and social life)? *(Please tick one box)*

   Not affected by the pain ☐
   Mildly affected by the pain ☐
   Moderately affected by the pain ☐
   Severely affected by the pain ☐
   Pain prevents any social life at all ☐

9. In the last two weeks, has the pain interfered with your ability to look after yourself, e.g. washing, dressing etc.? *(Please tick one box)*

   Not at all ☐
   Because of the pain, I needed some help looking after myself ☐
   Because of the pain, I needed a lot of help looking after myself ☐
   Because of the pain, I could not look after myself at all ☐

**SECTION B** **If you have neck pain please answer the following**

10. In your right arm, do you have pain in the following areas? *(Please tick all boxes that apply to you)*

    a) Pain in the shoulder ☐
    b) Pain in the upper arm ☐
    c) Pain in the forearm ☐
    d) Pain in the wrist/ hand ☐

11. In your left arm, do you have pain in the following areas?
*(Please tick all boxes that apply to you)*

a) Pain in the shoulder ☐
b) Pain in the upper arm ☐
c) Pain in the forearm ☐
d) Pain in the wrist/ hand ☐

12. Do you have any loss of feelings in your arms?
*(Please tick one box)*

No ☐
Yes, one arm ☐
Yes, both arms ☐

13. In your right arm, do you have any weakness or loss of power in the following areas? *(Please tick all boxes that apply to you)*

a) Pain in the shoulder ☐
b) Pain in the upper arm ☐
c) Pain in the forearm ☐
d) Pain in the wrist/ hand ☐

14. In your left arm, do you have any weakness or loss of power in the following areas? *(Please tick all boxes that apply to you)*

a) Pain in the shoulder ☐
b) Pain in the upper arm ☐
c) Pain in the forearm ☐
d) Pain in the wrist/ hand ☐

15. Are any of the following movements limited by pain?
*(Please tick all boxes that apply to you)*

a) Looking over right shoulder ☐
b) Looking over left shoulder ☐
c) Bending head to the side, so that the right ear approaches right shoulder ☐
d) Bending head to the side, so that the left ear approaches left shoulder ☐
e) Tilting head back ☐

16. In the last two weeks, did you suffer from headaches? *(Please tick one box)*

I had no headaches at all ☐
I had mild headaches which came infrequently ☐
I had moderate headaches which came infrequently ☐
I had moderate headaches which came frequently ☐
I had severe headaches which came frequently ☐
I had headaches which almost all the time ☐

**SECTION C** **If you have upper back pain, please answer the following**

17. Do you have pain the following areas of your chest?
*(Please tick all boxes that apply to you)*

a) Upper part of chest on the right ☐
b) Lower part of chest on the right ☐
c) Upper part of chest on the left ☐
d) Lower part of chest on the left ☐

18. Do you have pain in the following areas of your abdomen?
*(Please tick all boxes that apply to you)*

Upper abdomen on the right ☐
Lower abdomen and groin on the right ☐
Upper abdomen on the left ☐
Lower abdomen and groin on the left ☐

19. Are any of the following movements limited by pain?
*(Please tick all boxes that apply to you)*

a) Bending trunk forward ☐
b) Bending trunk backwards ☐
c) Bending trunk to the right side ☐
d) Bending trunk to the left side ☐
e) Twisting trunk to the right whilst sitting down ☐
f) Twisting trunk to the left whilst sitting down ☐

**SECTION D** **If you have lower back pain, please answer the following**

20. In your right leg, do you have pain in the following areas?
*(Please tick all boxes that apply to you)*

a) Pain in the buttock ☐
b) Pain in the thigh ☐
c) Pain in the shin/calf ☐
d) Pain in the foot/ankle ☐

21. In your left leg, do you have pain in the following areas?
*(Please tick all boxes that apply to you)*

a) Pain in the buttock ☐
b) Pain in the thigh ☐
c) Pain in the shin/calf ☐
d) Pain in the foot/ankle ☐

22. Do you have any loss of feeling in your legs? *(Please tick one box)*

No ☐
Yes, one leg ☐
Yes, both legs ☐

23. In your right leg, do you have any weakness or loss of power in the following areas? *(Please tick all boxes that apply to you)*

a) The hip ☐
b) The knee ☐
c) The ankle ☐
d) The foot ☐

24. In your left leg, do you have any weakness or loss of power in the following areas? *(Please tick all boxes that apply to you)*

a) The hip ☐
b) The knee ☐
c) The ankle ☐
d) The foot ☐

25. If you were trying to bend forwards <u>without bending your knees</u>, how far down do you think you could bend before the pain stopped you? *(Please tick one box)*

I could touch the floor ☐
I could touch my ankles with the tips of my fingers ☐
I could touch my knees with the tips of my fingers ☐
I could touch my mid-thighs with the tips of my fingers ☐
I couldn't bend forward at all ☐

**SECTION E** **If you have neck and/or upper back pain, please answer the following**

26. On the worst day during the last two weeks, did the pain interfere with your ability to read? *(Please tick one box)*

I could read as much as I wanted to without pain ☐
I could read as much as I wanted to with mild pain ☐
I could read as much as I wanted to with moderate pain ☐
I could not read as much as I wanted because of moderate pain ☐
I could hardly read at all because of severe pain ☐
I could not read at all because of severe pain ☐

27. On the worst day during the last two weeks, did pain interfere with your ability to drive? *(Please tick one box)*

I could drive my car without pain ☐
I could drive my car as long as I wanted with mild pain ☐
I could drive my car as long as I wanted to with moderate pain ☐
I could not my car as long as I wanted because of moderate pain ☐
I could hardly drive my car at all because of severe pain ☐
I could not drive my car because of severe pain ☐

**SECTION F** **If you have upper and/or lower back pain, please answer the following**

28. On the worst day during the last two weeks, how did the pain interfere with your ability to sit? *(Please tick one box)*

| | |
|---|---|
| I was able to sit on any chair as I wanted | ☐ |
| I could only sit on my favourite chair as long as I wanted | ☐ |
| Pain prevented my from sitting more than 1 hour | ☐ |
| Pain prevented me from sitting more than 30 minutes | ☐ |
| Pain prevented me from sitting more than 15 minutes | ☐ |
| Pain prevented me from sitting at all | ☐ |

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