PATIENT SCREENING FORM

Date of screening

NAME: AGE: GENDER:

Duration of pain:

NPRS

0 1 2 3 4 5 6 7 8 9 10
No pain More pain

Primary pain location Back
Secondary pain locations Ankle knee hip lower limbs

Upper back mid back buttock

Neck shoulder hand upper limbs
[More than two areas of pain include the patient]

Does pain affect your life?

Mobility /activities	YES	NO
Mood	YES	NO
Sleep	YES	NO
Recreation /relationships	YES	NO

[If any two 'YES' include the patient]

a. Infection	YES	NO
b.Tumour	YES	NO
c.Osteoporosis	YES	NO
d.Spine fracture/surgery	YES	NO
e.Structural deformity	YES	NO
f.Radiculopathies	YES	NO
g.Neurological conditions/Myopathies	YES	NO

[If a-g is 'NO' then include the patient]

Final Decision: Included: ☐ Excluded: ☐

If included get it assigned to relevant treatment group from central allocation

Experimental: ☐ Control: ☐

[Note: please return the screening form without fail irrespective of whether patient is included or excluded for the study]