

### Patient's Survey

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Month Day Year

#### A. Characteristics of Low Back Pain

- 1. Do you have low back pain? .....  Yes  No
- 2. In the past six months, how often have you experienced back pain? .....  Yes  No
- 3. Does your pain travel to one or both legs?.....  Yes  No

For Questions 4-6, use the scale from 0-10 with 0 being No Pain and 10 being Worst Pain Imaginable

4. In the past week, how would you rate your pain on average?  
No Pain 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10	

 Worst Pain Imaginable

5. In the past week, how much did pain interfere with your day-to-day activities?  
No Pain 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

 Worst Pain Imaginable

6. In the past week, how much did pain interfere with your enjoyment of life?  
No Pain 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

 Worst Pain Imaginable

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## B. Therapies and treatments already tried or are currently using for low back pain:

Therapy	Tried in past		Currently using	
	Yes	No	Yes	No
1. Analgesics (Non-opioid)..... Examples: Ibuprofen, naproxen, acetaminophen/Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Analgesics (Opioids)..... Examples: Hydrocodone/Vicodin, oxycodone/Percocet, codeine, morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Adjuvant analgesics ..... Examples: Antidepressants (Nortriptyline, amitriptyline, duloxetine, venlafaxine), Anticonvulsants (Gabapentin, pregabalin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Topical agents ..... Examples: Lidocaine, capsaicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Muscle relaxants ..... Examples: cyclobenzaprine, methocarbamol, carisopridol/Soma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Cognitive, behavioral or psychological therapy..... Examples: one-on-one or group talk therapy by a psychologist or other mental health provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Relaxation techniques ..... Examples: breathing, guided imagery, or progressive muscle relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Physical therapy/exercise ..... Examples: Stretching/strengthening, aerobic exercise therapy or home exercise program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Injections..... Examples: Epidural injections, disc procedures, facet injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Complementary and alternative therapies: <b>Yoga</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Complementary and alternative therapies: <b>Acupuncture</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Complementary and alternative therapies: <b>Chiropractic care</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### C. Attitudes towards specific therapies (with brief descriptions, course of treatment):

Please rank the following types of low back pain treatments in your order of preference to receive.

(1=most preferred, 10=least preferred)

- |  |                      |        |
|--|----------------------|--------|
| 1. Acupuncture.....                        | <input type="text"/> | (1-10) |
| 2. Chiropractic care.....                  | <input type="text"/> | (1-10) |
| 3. Marijuana (inhaled and oral).....       | <input type="text"/> | (1-10) |
| 4. Massage.....                            | <input type="text"/> | (1-10) |
| 5. Medications (oral and topical).....     | <input type="text"/> | (1-10) |
| 6. Physical therapy/exercise.....          | <input type="text"/> | (1-10) |
| 7. Psychological/behavioral therapies..... | <input type="text"/> | (1-10) |
| 8. Spinal injections.....                  | <input type="text"/> | (1-10) |
| 9. Surgery.....                            | <input type="text"/> | (1-10) |
| 10. Yoga.....                              | <input type="text"/> | (1-10) |

Are there other treatments that you feel should be offered for treating low back pain? (Free text)

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## D. Interest in participating in a back pain research study

The VA is planning a study to identify the best approach to treat chronic low back pain. This study would involve patients being assigned to receive one of a few treatment options commonly recommended to patients suffering from low back pain. Most of the options would involve several weeks of active treatment followed by occasional assessments for up to one year. Some travel to a local VA clinic or possibly a VA hospital facility would be required. There would be no charges for the treatments, and travel costs would be reimbursed.

Are you interested in participating in a low back pain study (0-10, not at all interested -> very interested)

Not at all interested 0 1 2 3 4 5 6 7 8 9 10 Very interested

## E. Demographics

1. Age  years

2. Sex  Male  Female

3. Race (select all that apply)

- American Indian/Alaskan Native  Asian  Native Hawaiian/Pacific Islander
- Black/African American  White/Hispanic  White/Non-Hispanic
- Prefer not to answer

4. Approximate distance from nearest VA hospital facility (if known)

miles  Unknown distance

F. Would you be willing to discuss your thoughts and feelings about participating in a VA-sponsored back pain study? If yes, a member of our team may contact you by phone.

- Yes, a research team member may contact me
- No, please do not contact me

# Provider's Survey

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The VA is considering conducting a study to identify the optimal approach to the treatment of chronic low back pain. This study would involve patients being randomly assigned to receive one of several treatments similar to those described in this survey. Most of the options would involve several weeks of active treatment followed by occasional assessments for up to one year. Your input to this brief survey will help to shape the final design of the study.

A. Please estimate the number of patients in your panel that you feel might be candidates for this type of study.

# of candidates

B. Attitudes towards specific therapies (with brief descriptions, course of treatment):

Please rank the following types of low back pain treatments in your order of preference to make available to your patients. It is understood that some of the listed options are not available through your medical center or easily accessed in the surrounding community at this time.

(1=most preferred, 10=least preferred)

1. Acupuncture .....	<input type="text"/>	(1-10)
2. Chiropractic care .....	<input type="text"/>	(1-10)
3. Marijuana (inhaled and oral).....	<input type="text"/>	(1-10)
4. Massage.....	<input type="text"/>	(1-10)
5. Medications (oral and topical) .....	<input type="text"/>	(1-10)
6. Physical therapy/exercise .....	<input type="text"/>	(1-10)
7. Psychological/behavioral therapies .....	<input type="text"/>	(1-10)
8. Spinal injections .....	<input type="text"/>	(1-10)
9. Surgery .....	<input type="text"/>	(1-10)
10. Yoga.....	<input type="text"/>	(1-10)

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Are there other treatments that you feel should be offered for treating low back pain?

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**C. Interest in participating in a chronic low back pain research study.**

Would you refer your patients to this type of study?  Yes  No

**D. Would you be willing to discuss you thoughts and feelings about referring patients to participate in a VA-sponsored back pain study? Indicate yes if a member of our team can contact you by phone.**

Yes  No

## Appendix 2

### Follow-up questions for patients

1. [Collect NRS now at the time of interview]. Before we get into other questions, would you mind sharing with me how your pain is today? On a scale of zero to 10 how bad is your pain?
2. What are your most important goals for back pain treatment?
  - a. Pain relief itself, ability to function, sleep, etc.
3. To best meet your pain care needs and desires, what treatment options should be included in this study? Why?
4. Related to therapies that tend to be most preferred:
  - a. What is attractive about the option?
    - i. Rapid response, costs (could include travel, time off work), convenience, good responses in the past, low risks, confidence in the approach, etc.
5. Related to therapies least preferred:
  - a. What makes the option unattractive?
    - i. Tried previously, risks, costs, inconvenience, lack of confidence in the approach, etc.
6. Willingness to participate in the study described:
  - a. What is attractive about the study?
    - i. Ability to try new treatments, participation in veteran's care, etc.
  - b. What concerns you about the study?
    - i. The options available, lack of choice, time commitment, privacy concerns, compensation, etc.
7. Are there any barriers or challenges you would have to overcome to participate in the study?
8. What would make you want more strongly to participate in this study?
9. As a final question, if you could recommend the ideal pain treatment program you would like to see offered, what would it look like?

### Follow-up questions for providers

1. What are your most important treatment goals for your patients with back pain?
  - a. Pain relief itself, ability to function, sleep, etc.
2. Related to therapies that tend to be most preferred:
  - a. What is attractive about the option?
    - i. Rapid response, costs (could include travel, time off work), convenience, good responses in the past, low risks, confidence in the approach, etc.

3. Related to therapies least preferred:
  - a. What makes the option unattractive?
    - i. Tried previously, risks, costs, inconvenience, lack of confidence in the approach, etc.
4. What important barriers or challenges do you (or your patients) face when referring them to X,Y,Z options
5. What additional treatment options should be included in this study?
6. As a final question, if you could recommend the ideal pain treatment program you would like to see offered, what would it look like?