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Appendix 2

SYMPTOMS

How often have you had symptoms in the last three months? (body parts A-I in the picture below)? Mark the appropriate option.

	Almost daily	More than once a week	About once a week	About once a month	Seldom or never
Headache (A)	O	O	O	O	O
Neck or shoulder pain / ache (B)	O	O	O	O	O
Upper extremities pain / ache (C)	O	O	O	O	O
Chest pain / ache (D)	O	O	O	O	O
Upper back pain / ache (E)	O	O	O	O	O
Lower back pain / ache (F)	O	O	O	O	O
Stomach ache (G)	O	O	O	O	O
Buttocks pain / ache (H)	O	O	O	O	O
Lower extremities pain / ache (I)	O	O	O	O	O
Difficulty falling asleep	O	O	O	O	O
Waking up at night	O	O	O	O	O

Have you injured any of the above-mentioned and pictured pain areas during the previous three months (for example, fallen, stumbled, breached during sport, etc.)

- O No
- O Yes

If you answered "Yes" to the previous question, please indicate the injured body areas. You can choose several options.

- O B
- O C
- O D
- O E
- O F
- O G
- O H
- O I