FEAR-AVOIDANCE BELIEFS QUESTIONNAIRE (F.A.B.Q.)

PATIENT NAME: _____ **DATE:** _____

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect *your* back pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity……	0	1	2	3	4	5	6
2. Physical activity makes my pain worse……..	0	1	2	3	4	5	6
3. Physical activity might harm my back……	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse…….	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse…….....	0	1	2	3	4	5	6

The following statements are about how normal work affects or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
6. My pain was caused by my work or by an accident at work……..	0	1	2	3	4	5	6
7. My work aggravated my pain……..	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain……	0	1	2	3	4	5	6
9. My work is too heavy for me……	0	1	2	3	4	5	6
10. My work makes or would make my pain worse……	0	1	2	3	4	5	6
11. My work might harm my back……..	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain……..	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain……	0	1	2	3	4	5	6
14. I cannot do my normal work till my pain is treated……...	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months……..	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work……..……	0	1	2	3	4	5	6