PAIN

1. Do you have bodily pain presently, that has lasted for more than 6 months??
   Yes ☐ No ☐

2. How severe bodily pain have you experienced during the last 4 weeks?
   None ☐ Very weak ☐ Weak ☐ Moderate ☐ Severe ☐ Very severe ☐

MUSCLES AND JOINTS

3. Have you during the last year been troubled with pain and/or stiffness in muscles or joints, that has lasted for minimum 3 months continuously? (If no, proceed to HEADACHE)
   Yes ☐ No ☐

4. If yes: Where have you had these symptoms? (Mark one or more boxes)
   Neck ☐ Upper back ☐ Lower back ☐ Hip ☐ Shoulder ☐ Elbows ☐ Wrist / hands ☐ Ankle / feet ☐ Knees ☐

5. Have you been troubled in both right and left half of the body?
   Yes ☐ No ☐

6. Has the pain hindered you in performing daily activities?
   During work ........................................
   Yes ☐ No ☐
   In leisure time .....................................
   Yes ☐ No ☐
HEADACHE

7. Have you been troubled with headache the last year?  
   Yes □ No □  
   If yes: What type of headache:  Migraine □ Other headache □  

8. Ca. number of days per month with headache:  
   Less than 1 day □ 1-6 days □ 7-14 days □ More than 14 days □  

9. How strong is the headache usually?  
   Mild (does not hamper activity) □  
   Moderate (hampers activity) □  
   Strong (hinders activity) □  

10. Is the headache usually characterised or accompanied by:  
    (Put one mark per row)  
    Throbbing/pulsatory pain? ................................................................. □  
    Pressing pain? .................................................................................. □  
    One-sided pain (right or left)? ........................................................... □  
    Worsens with moderate physical activity? ....................................... □  
    Nausea and/or vomiting? .................................................................. □  
    Photophobia or phono phobia? .......................................................... □  

11. Before or during the headache, do you sometimes have:  
    (Put one mark per row)  
    Distorted vision? (jagged lines, flickering, blurred vision, flash of light)  □  
    Numbness in one side of the face or in the hand? ....................... □  

12. Indicate how many days you have been absent from work or school the last month due to headache:  □ days  

SLEEP  

13. How often has it happened in the course of the last 3 months that you:  
    Never □ Seldom □ Occasionally (some times per month) □ Mostly (several times per week) □ Always (daily) □  
    Snore loudly and bothersome? .................................................. □  
    Get breathing stops while sleeping? ................................. □  
    Find it difficult to fall asleep at night? .......................... □  
    Wake up repeatedly at night? ................................. □  

Wake up too early and can’t get back to sleep?  □ □ □ □ □ □
Feel sleepy during the day? ......................... □ □ □ □ □ □
Wake up with a headache? ......................... □ □ □ □ □ □
Get discomfort or tingling in legs? .... □ □ □ □ □ □
Have unintended sleep episodes (“head bobbing”) at work or school? ....... □ □ □ □ □ □
Have unintended sleep episodes (“head bobbing”) in your free time? ......................... □ □ □ □ □ □

14. How often are you bothered by insomnia?
  Never, or a few times a year ............... □  About once a week ......................... □
  1-2 times a month .......................... □  More than once a week .................. □

15. Have you during the last year been bothered by insomnia affecting your ability to work?
  Yes □  No □

16. Have you during the last month had problems falling asleep? *Mark only one alternative*
  Almost every night .......................... □  Occasionally .......................... □
  Often ........................................ □  Never ..................................... □

17. Have you during the last month woken up too early without getting back to sleep? *Mark only one alternative*
  Almost every night .......................... □  Occasionally .......................... □
  Often ........................................ □  Never ..................................... □

18. When do you normally go to bed to sleep?
  During working week at ________ o’clock
  In your free time at ________ o’clock

19. When do you normally wake up? (final awakening)
  During working week at ________ o’clock
  In your free time at ________ o’clock

20. For how long do you stay awake (in bed) before you fall asleep? (Number of minutes)
  During working week ________ minutes
  In your free time ________ minutes

21. How much sleep do you need? (Number of hours) _____ timer

22. How many hours do you sleep on average per 24? (night + daytime sleep) _____ timer

23. Do you think you get sufficient/ enough sleep?
  Yes, nearly always □  Yes, often □
  Seldom or nearly never □  Don’t know □