



Risks of Occupational Vibration Exposures

VIBRISKS

FP5 Project No. QLK4-2002-02650
January 2003 to December 2006

Supplement 5 to Annex 12 of Final Technical Report

Title:

WBV questionnaire: Southampton
low back pain drivers study

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Quality of Life and Management of Living Resources Programme
Key Action 4 - Environment and Health



4th December 2005

SERIAL NO:



University
of Southampton



MEDICAL RESEARCH COUNCIL

isvr

HUMAN FACTORS RESEARCH UNIT

Southampton Survey of Work Activities and Health

The answers given on this form are confidential.
Replies will ONLY be seen by the small research team.

SECTION B: YOUR CURRENT JOB

12. When did you start your current job as a taxi driver?

month

year

13. How many hours per week do you normally work in this job?

 hours

14. Are you employed or self-employed?

Employed

Self-employed

Do you work as a taxi driver

Full-time

Part-time

ACTIVITIES IN YOUR JOB

We are interested in the physical activities that you carry out in **an average working day** in your job as a taxi driver. Please think about the pattern of activity in a typical work day and tick the most appropriate box(es).

Lifting

15. How many **times** in an average working day do you lift loads greater than 15 kg (30 lbs) - e.g. an average child of three or a small suitcase with belongings?

Not at all

1 - 10 times

More than 10 times

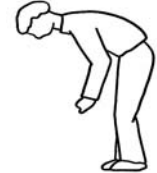
If Not at all, please go to question 17.

16. And how many **times** in an average working day do you lift such a load **whilst your back is in a bent position**, as shown?

Not at all

1 - 10 times

More than 10 times



16a. And how many **times** in an average working day do you lift such a load **whilst your back is in a twisted position**, as shown?

Not at all

1 - 10 times

More than 10 times



16b. And how many **times** in an average working day do you lift such a load **whilst your back is in a bent and twisted position**, as shown?

Not at all

1 - 10 times

More than 10 times



Digging

17. Does an average working day involve digging or shovelling?

No

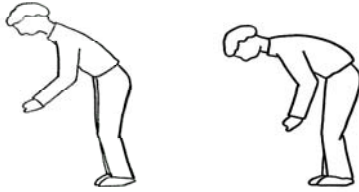
Yes

Posture

18. During an average day in the job, how many hours in total are spent standing or walking?

None Less than an hour 1 - 3 hours More than 3 hours

19. Does an average working day involve bending as shown below (other than while lifting)?



No Yes

If NO, please go to question 20.

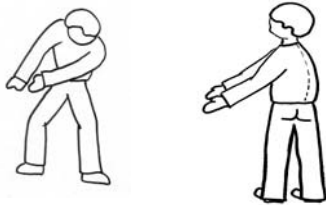
19a. If **YES**, how many times in an average working day do you bend over in such a position?

Less than 5 times 5 - 20 times more than 20 times

19b. And, if you add together all the time in an average working day that you spend in such a position, how many hours does that make?

Less than an hour 1 - 3 hours More than 3 hours

20. Does an average day in the job involve twisting as shown below (other than while lifting)?



No Yes

If NO, please go to question 21

20a. If **YES**, how many times in an average working day do you twist like this?

Less than 5 times 5 - 20 times More than 20 times

20b. And, if you add together all the time in an average working day that you spend in such a twisted position, how many hours does that make?

Less than an hour 1 - 3 hours More than 3 hours

21. During an average working day, how many hours in total are spent sitting (other than when driving but including periods when you sit in your vehicle but not driving)?

Less than an hour 1 - 3 hours More than 3 hours

22. Does an average working day involve sitting for longer than three hours at a time?

No Yes, but I **can** get up and move around when I want to Yes, but I **cannot** get up and move around even if I want to

Professional Driving

23. Which type of vehicle do you normally drive in the job, and for how many hours per week on average?

*Total driving time (per week)**

<i>Type of vehicle</i>	<i>Tick if driven in the job</i>	<i>hrs</i>	<i>mins</i>
a) Purpose build taxi (TX1, TX2, Fairway, Metrocab, etc.)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
b) Purpose adapted taxi (Peugeot E7, Fiat Eurocab, etc.)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
c) Saloon car (Mondeo, Vectra, BMW 5, Volvo, etc.)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
d) MPV (Renault Scenic, etc.)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
e) Other (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

* *Total driving time (per week): time vehicle is being driven*

24. During an average working day, how many hours in total are spent driving (include only the time vehicle is being driven)?

Less than an hour 1 - 3 hours More than 3 hours

25. Do you ever have to drive with your back bent forward or twisted in the job?

Seldom/never Often

26. Do you regularly have to load or unload the vehicle(s) you drive by moving heavy materials or equipment by hand? No Yes

27. During a typical working week, how much of the time do you spend driving off road in your job?

Not at all Less than an hour 1 - 3 hours More than 3 hours

29. Does the vehicle you normally drive have automatic gears? No Yes

Your views about your job

30. In your job, do you have a choice in deciding:

	<i>Often</i>	<i>Sometimes</i>	<i>Seldom</i>	<i>Never/almost never</i>
a) How you do your work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) What you do at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Your work timetable and breaks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. When you have difficulties in your work, how often do you get help and support from your colleagues or immediate line manager?

Often Sometimes Seldom Never Not applicable

32. How satisfied have you been with your job as a whole, taking everything into consideration?

Very satisfied Satisfied Dissatisfied Very dissatisfied

SECTION C: OTHER JOBS YOU MAY HAVE HELD

Complete this section **only** if you have held other jobs in the past. **Otherwise go to Section D.**

33. We are interested in your previous work – including, the kind of job, when it was done, and whether or not it involved professional driving. Please fill in the table below to show **all of the jobs you've held for a year or more.**

Ignore the job you may have told us about in Section B. But include all the other jobs held for a year or more, beginning with the first job after leaving school or higher education.

Age started	Age stopped	Occupation	Which vehicle(s) did you drive professionally in the job? (✓) (Do not include journeys to and from work)								
			None	Car or van	Bus or lorry	Motor-cycle	Fork-lift truck	Tractor	Loader	Dump or excavator	Other large vehicle (describe)
□□ age in years	□□ age in years	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
□□ age in years	□□ age in years	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
□□ age in years	□□ age in years	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
□□ age in years	□□ age in years	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check that the table includes all jobs held for a year or more (excluding any current one). If you need more space attach an extra sheet here.

34. Did your previous job(s) involve prolonged sitting? No Less than an hour per day 1 - 3 hours per day More than 3 hours per day

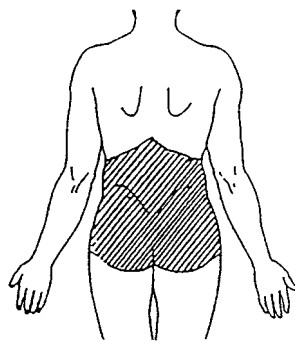
35. Did your previous job(s) involve heavy physical demands (e.g. frequent heavy lifting)? No Yes

SECTION D: YOUR HEALTH: ACHES AND PAINS

This section concerns *aches and pains* you may have had in different parts of the body and at different times.

THE FIRST FEW QUESTIONS FOCUS ON PAIN IN THE LOW BACK

36. During the **past 12 months** have you had **back pain** in the area shown in the diagram, which lasted more than a day? (Don't include pain occurring only during pregnancy, menstrual periods or the course of a feverish illness such as 'flu.)



No Yes

If **NO**, go straight to question 52.

If **YES**:

- 36a. How long in total during the **past 12 months** has this low back pain been present? (Tick one.)

1 - 2 days

3 - 6 days

7 - 30 days

1 - 3 months

More than 3 months

37. How much time in total have you taken off work in the **past 12 months** because of low back pain?

None

1 - 6 days

7 - 14 days

15 - 30 days

1 - 3 months

More than 3 months

38. Have you visited a doctor because of this low back pain during the **past 12 months**? No Yes

39. Has the pain spread down your leg to below your knee during the **past 12 months**? No Yes

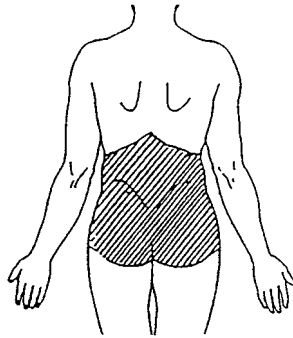
40. Has the pain made it difficult or impossible to put on your shoes, socks, stockings, or tights during the **past 12 months**? No Yes

41. Do you get back pain while driving? No Yes

42. Do you get back pain shortly after driving? No Yes

Your back in the PAST 4 WEEKS *The next few questions focus on your back in the past 4 weeks*

43. During the **past 4 weeks** have you had **low back pain** (as shown in the diagram) which lasted more than a day? (*Don't include pain occurring only during pregnancy, menstrual periods or the course of a feverish illness such as 'flu.'*)



No Yes

If NO, go straight to question 49.

44. These questions are about the way your back pain is affecting your daily life. We would like to know if you are, or have been in the past 4 weeks in any of the situations listed below (please tick all the items that apply).

(Please tick all the items that apply.)

	<i>No</i>	<i>Yes</i>
a) I stay at home most of the time because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
b) I change position frequently to try and get my back comfortable.	<input type="checkbox"/>	<input type="checkbox"/>
c) I walk more slowly than usual because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
d) Because of my back, I am not doing any of the jobs that I usually do around the house.	<input type="checkbox"/>	<input type="checkbox"/>
e) Because of my back, I use a handrail to get upstairs.	<input type="checkbox"/>	<input type="checkbox"/>
f) Because of my back, I lie down to rest more often.	<input type="checkbox"/>	<input type="checkbox"/>
g) Because of my back, I have to hold onto something to get out of an easy chair.	<input type="checkbox"/>	<input type="checkbox"/>
h) Because of my back, I try to get other people to do things for me.	<input type="checkbox"/>	<input type="checkbox"/>
i) I get dressed more slowly than usual because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
j) I only stand up for short periods of time because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
k) Because of my back, I try not to bend or kneel down.	<input type="checkbox"/>	<input type="checkbox"/>
l) I find it difficult to turn over in bed because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
m) My back is painful almost all the time.	<input type="checkbox"/>	<input type="checkbox"/>
n) I find it difficult to get out of a chair because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
o) My appetite is not very good because of my back pain.	<input type="checkbox"/>	<input type="checkbox"/>
p) I have trouble putting on my socks (or tights) because of the pain in my back.	<input type="checkbox"/>	<input type="checkbox"/>
q) I only walk short distances because of my back pain.	<input type="checkbox"/>	<input type="checkbox"/>
r) I sleep less well because of my back pain.	<input type="checkbox"/>	<input type="checkbox"/>
s) Because of my back pain, I get dressed with help from someone else.	<input type="checkbox"/>	<input type="checkbox"/>
t) I sit down for most of the day because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
u) I avoid heavy jobs around the house because of my back.	<input type="checkbox"/>	<input type="checkbox"/>
v) Because of my back pain, I am more irritable and bad tempered with people than usual.	<input type="checkbox"/>	<input type="checkbox"/>
w) Because of my back pain, I go upstairs more slowly than usual.	<input type="checkbox"/>	<input type="checkbox"/>
x) I stay in bed most of the time because of my back.	<input type="checkbox"/>	<input type="checkbox"/>

And now your back in the PAST 7 DAYS

45. During the **past 7 days** have you had **low back pain** which lasted more than a day? No Yes

If NO, go to question 49.

45a. If **YES**, has the pain spread down your leg to below your knee during the **past 7 days**? No Yes

46. Has the back pain made it difficult or impossible for you to put on shoes, socks or tights in the **past 7 days**? No Yes

47. Have you had any time off work because of back pain in the **past 7 days**? No Yes

48. How would you rate your low back pain on a 0 - 10 scale during a typical day in the **past 7 days** (where **0 = no pain** and **10 = worst pain you can imagine**)?

No pain

*(Please circle one number)
Worst pain you can imagine*

0 1 2 3 4 5 6 7 8 9 10

Finally your back when symptoms FIRST BEGAN

49. When this low back pain **first** started, did it come on gradually or suddenly?

Gradually

Suddenly outside work

Suddenly at work

50. If this came **suddenly**, when did you first experience it? Year month

50a. And if **suddenly**, what were you doing at the time?

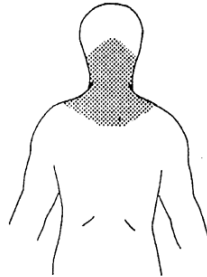
51. Have you ever had an accident to your back that required medical advice? *If NO, go to question 52.* No Yes

51a. If **YES**. What type of accident?

51b. When did it happen? Year month

The next few questions focus on pain in your NECK

52. During the **past 12 months** have you had **neck pain** (in the area shown in the diagram) which lasted more than a day?



No Yes

If NO, go straight to question 59.

- 52a. How long in total during the **past 12 months** has this neck pain been present? (*Tick one.*)

1 - 2 days

3 - 6 days

7 - 30 days

1 - 3 months

More than 3 months

53. How much time in total have you taken off work in the **past 12 months** because of neck pain?

None

1 - 6 days

7 - 14 days

15 - 30 days

1 - 3 months

More than 3 months

54. Have you visited a doctor because of this neck pain during the **past 12 months**? No Yes

55. Have you had this neck pain during the **past 4 weeks**? No Yes

56. Have you had neck pain which lasted a day or more in the **past 7 days**? No Yes

If NO, go to question 57.

- 56a. If **YES**, how would you rate your neck pain on a 0 - 10 scale during a typical day in the **past 7 days** (where **0 = no pain** and **10 = worst pain you can imagine**)?

No pain

*(Please circle one number.)
Worst pain you can imagine*

0

1

2

3

4

5

6

7

8

9

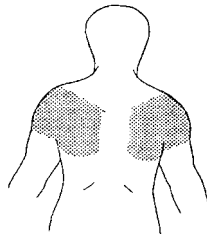
10

57. Do you get neck pain while driving? No Yes

58. Do you have neck pain shortly after driving? No Yes
-

Finally, in this section, some questions about pain in your SHOULDER(S)

59. During the **past 12 months** have you had **shoulder pain** (in the area shown in the diagram) which lasted more than a day?



No Yes

If **NO**, go straight to question 67.

59a. How long in total during the **past 12 months** has this shoulder pain been present? (*Tick one.*)

1 - 2 days 3 - 6 days 7 - 30 days
 1 - 3 months more than 3 months

60. How much time in total have you taken off work in the **past 12 months** because of shoulder pain?

None 1 - 6 days 7 - 14 days
 15 - 30 days 1 - 3 months More than 3 months

61. Have you visited a doctor because of this shoulder pain during the **past 12 months**? No Yes

62. Have you had this shoulder pain during the **past 4 weeks**? *If NO, go to question 65.* No Yes

63. During the **past 4 weeks**, when your shoulder pain was **at its worst**, how much difficulty did you have with the following activities?

(Please tick all the activities that apply.)

<i>Activities</i>	<i>No difficulty</i>	<i>Difficult</i>	<i>Impossible</i>
a) Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Carrying bags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Opening doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Routine jobs around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

64. Have you had shoulder pain lasting a day or more in the **past 7 days**? No Yes

If NO, go to question 65.

64a. If **YES**, how would you rate your shoulder pain on a 0 - 10 scale during a typical day in the **past 7 days** (where **0 = no pain** and **10 = worst pain you can imagine**)?

(Please circle one number.)

No pain

Worst pain you can imagine

0 1 2 3 4 5 6 7 8 9 10

65. Do you get shoulder pain while driving? No Yes

66. Do you get shoulder pain shortly after driving? No Yes

SECTION E: OTHER SYMPTOMS AND FEELINGS

This section concerns *other symptoms* and your *feelings* about health problems.

67. Firstly, some questions about how you feel and how things have been with you **during the past 4 weeks**. Please tick the one box for each question which most closely reflects how you feel.

How much of the time during the past 4 weeks	<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
a) ...did you feel full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) ...have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) ...have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) ...have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) ...did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) ...have you felt downhearted and low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) ...did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) ...have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) ...did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

68. During the past **12 months**, how many days of sick leave have you taken (for all reasons combined)?

- None
 1 - 2 days
 3 - 6 days
 7 - 30 days
 1 - 3 months
 More than 3 months

69. Below is a list of problems people sometimes have. Please read each one carefully and circle the number that best describes how much that problem has distressed or bothered **you** during the **past 7 days including today**.

	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
a) Faintness or dizziness.	0	1	2	3	4
b) Pains in the heart or chest.	0	1	2	3	4
c) Your feelings being easily hurt.	0	1	2	3	4
d) Feeling that people are unfriendly or dislike you.	0	1	2	3	4
e) Feeling inferior to others.	0	1	2	3	4
f) Nausea or upset stomach.	0	1	2	3	4
g) Trouble getting your breath.	0	1	2	3	4
h) Numbness or tingling in parts of your body.	0	1	2	3	4
i) Feeling weak in parts of your body.	0	1	2	3	4
j) Feeling very self-conscious with others.	0	1	2	3	4

70. Whether you have back pain or not, based on your own views and what the doctor or others may have told you about pain in the back, how strongly do you agree with the following statements?

Please circle one number for each statement which most closely reflects how you feel.

1 means you completely disagree, 5 means you completely agree.

	<i>Completely disagree</i>				<i>Completely agree</i>
a) Physical activity worsens back pain	1	2	3	4	5
b) Physical activities should be avoided if they might make the pain worse.	1	2	3	4	5
c) An increase in pain is an indication to stop what one is doing.	1	2	3	4	5
d) Rest is needed to get better.	1	2	3	4	5
e) Normal work should be avoided until the pain is treated.	1	2	3	4	5
f) It is important to see a doctor straight away at the first sign of trouble.	1	2	3	4	5
g) Neglecting problems of this kind can cause permanent health problems.	1	2	3	4	5
h) Back pain normally gets better by itself.	1	2	3	4	5

You have finished. Please take a moment to look through your answers. Return the questionnaire to us in the pre-paid envelope supplied.

Once again thank you for your time and help