**Additional file 3** Checklist for electronic patient record data.

|  |
| --- |
| ID |
| Date of consent |
| First contacted professional:physician/nurse and physician/physiotherapist/nurse alone |
|  |
| **Number of LBP-related appointments** | **3 months** | **12 months** |
| Physiotherapist  |  |  |
| Nurse |  |  |
| Physician |  |  |
| Physiatrist  |  |  |
| Orthopaedist |  |  |
|  |  |  |
| All primary care contacts |  |  |
| Number of LBP-related sick leave days  |  |  |
|  |
| RTG (X-ray) yes/no |  |  |
| MRI yes/no |  |  |
| CT yes/no  |  |  |