NECK PAIN QUESTIONNAIRE

Patient Name: ________________________________ Date: ______________________

How long have you had neck pain?

Is your neck pain rapidly getting worse? Yes / No

Is your neck pain secondary to major trauma (car accident, fall from height)? Yes / No
If yes, describe in detail:

If from car accident, fill out *Motor Vehicle Accident Questionnaire*

Is your neck pain secondary to minor trauma? If yes, describe in detail: Yes / No

Do you have a history of cancer? Describe: Yes / No

Have you recently experienced fever, chills or unexplained weight loss? Yes / No

Have you recently experienced a bacterial infection, IV drug use or immune system suppression from corticosteroids, transplant or HIV? Yes / No

Are you experiencing pain that has no specific mechanical exacerbating or remitting factors? Yes / No

Is your neck pain associated with symptoms in your arms and/or legs? Yes / No
Describe in detail:

Is your neck pain associated with a sudden onset of severe headache? Yes / No

Do you suffer from headaches? If yes, fill out *Headache Questionnaire*

Is your neck pain associated with recent changes in your mood or personality? Yes / No

Is your neck pain associated with difficulty swallowing, balancing or dizziness? Yes / No

Is your neck pain associated with vomiting or nausea? Yes / No

Is your neck pain induced by coughing, sneezing, straining or bending forward? Yes / No

Is your neck pain associated with visual disturbances? Yes / No

What specifically aggravates your neck pain?
☐Sitting ☐Standing ☐Coughing ☐Sneezing
☐Kneeling ☐Lying Down ☐Walking ☐Lifting
☐Computer Work ☐Using Phone ☐Chin to Chest ☐Looking at Ceiling
☐Turning head to left ☐Turning head to right ☐Left ear to shoulder ☐Right ear to shoulder
☐Bowel Movements ☐Pushing
☐Other, describe:

What specifically alleviates your neck pain?
☐Nothing ☐Lying Down ☐Hot Packs ☐Cold Packs ☐Massage ☐Manipulation
☐Exercise ☐Stretching ☐Traction ☐Electrical Stimulation ☐Ultrasound
☐Medications, describe:
☐Resting in specific position, describe:
☐Other, describe:

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How would you describe your neck pain?

□Dull	□Aching	□Burning	□Sharp / Stabbing	□Electrical
□Pins / Needles	□Deep	□Superficial	□Tingling	□Numbing

□Other, describe:

Does your neck pain spread? Yes / No

If it spreads, where does it start and where does it go?

If it is pin-point pain, where is it?

On a scale of 1 to 10, 1 being very minimal pain and 10 being the worst pain you can imagine, circle how you would rate your neck pain:

At it's best: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

At it's worst: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

On average: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

What % of the time do you experience your neck pain?

Daily: 0%---------------25%---------------50%---------------75%---------------100%

Weekly: 0%---------------25%---------------50%---------------75%---------------100%

Monthly: 0%---------------25%---------------50%---------------75%---------------100%

Does your neck pain interfere with your ability to:

□Sleep, describe:

□Work, describe:

□Exercise, describe:

□Other, describe:

At what time of the day is your neck pain at it's worst?

At what time of the day is your neck pain at it's best?

Have you experienced this pain in your neck before? Yes / No

History of Previous Evaluations / Treatments For Your Neck Pain

Who have you seen previously for your neck pain? Describe who, when, diagnosis and treatment previously received:

Have you received any special tests previously for your neck pain i.e. MRI, X-ray? Describe:

Which previous treatment(s) did you find most beneficial?

Which previous treatment did you find least beneficial?

What do you think is causing your neck pain?