NECK QUESTIONNAIRE

Patient	Name:				DOB:				
1.)		our distribut I, fingers/thu			oulder bla	ade, fron	t/back o	f uppe	r arm, forearm,
2.)	Do you hav	ve numbness	/tingling?	Does it radiat	e in the s	ame distr	ibutioní	P Be s	pecific.
	Is this work	c comp? ur job descri	Yes N ption?	0	Litigatio	n pendin	g? Y	es	No
	hrs./da	ay, days,	week W	/hat is your c	ırrent job	status? _			
5)	When did v	ou hurt vou	r neck?						
				ou doing whe					
7 \	Pata vour r			or most pain		\10			
7.) Rate your pain (0 for no pain, 10 for most pain):\8.) Describe your pain (circle all that apply):									
	sharp du	ll stabbir	ng b	urning	throbbin	ng a	ching		
9.)	When is th	e pain the w	orst? Do y	ou have pain	at night o	r at rest?	Be spe	cific.	
10.) What mak	es the pain v	worse (circl	e all that app	ly)?				
	Standing	walkin	g ly	ing in bed	coughing	g s	neezing		lifting
	bending	sitting		neezing		g from sit	ting to s	tandir	ng
	Other:								
11.) What impi	oves your p	ain (circle a	all that apply)	?				
	Rest ice	heat	standing	sitting	Ihunrofo	n /Alovo	т	ylenol	
								yieiioi	
	Other:								
12.) Do you ha	ve any of the	e following	(circle any th	at apply)?				
	History of o	cancer	unexplain	ed weight los	S (current in	nfection	/immu	ne suppression
	Traumatic	injury	bowel/bla	adder dysfund	tion	major mo	otor wea	kness	

	ymptoms? Be specific.	
15.) Do you drink regularly? \(\) 16.) Do you have history of p 17.) Do you have prior history	orior neck surgery? Yes no	s no
18.) Did the treatment help? 19.) Have you had any x-rays,	Yes No s/MRI/CT or other prior imaging studies? Yes	No
If yes, what study and wl		
questions have been acura	vsician to release any information including the diagnosis and the records of a	ny treatment
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