NECK QUESTIONNAIRE

Patient Name: ____ DOB: ____________________________

1.) Where does your neck hurt? ____

2.) Is this a new presentation of neck pain, or a follow-up?_______________________________________

3.) Did another provider refer you? If yes, who?____

4.) What is your hand dominance?

__ambidextrous __left hand dominant __right hand dominant __no dominance

5.) Describe **how** and **where** your symptoms occurred/how you injured your neck? Be specific (include **dates**)

____

____

6.) What best describes your neck pain? (check all that apply)

__acute
__aching
__burning
__catching
__clicking
__popping
__chronic
__constant
__cramp-like
__dull
__improving with activity
__intermittent
__painful
__radiating
__radiating into both hands
__radiating into the left hand
__radiating into the right hand
__sharp
__shooting down the arms
__shooting into the shoulder region
__stabbing
__tender to touch
__worse at night
__worse during the day
__worse in the morning
__worse with activity
__worse with sitting
__worst with standing
other:____________________

7.) Describe the timing of your pain? (check all that apply)

__acute
__acute on chronic
__chronic
__episodic
__intermittent
__random
__variable
__worse at the end of the day
__worse during activity
__worse during the day
__worse during the night
__worse in the morning
other:________________

8.) What is associated with your neck pain? (check all that apply)

__bowel problems
__chills
__clumsiness
__difficulty walking
__fevers
__headaches
__joint pain
__numbness
__shoulder pain
__tingling
__urinary problems
__weakness
other:_________________

9.) What aggravates or alleviates your pain? (check all that apply)

__improves with pain medication
__improves with physical therapy
__improves with rest
__improves with stretching
__worsens with bending
__worsens with exercise
__worsens with lifting
__worsens with neck movement
other:___________________

10.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___/10 on a bad day ___/10 on an average day ___/10

initially ___/10 on a good day ___/10

11.) How severe if your arm pain on a scale of 0-10? (if applicable) ___/10

12.) How long have you had your neck pain? ___years ___months ___weeks ___days

13.) What are you currently using to treat the neck pain? (check all that apply)

__acupuncture __injections __traction __weight reduction
__activity modification __neck brace __topical cream __yoga
__anti-inflammatory meds __muscle relaxants __Tylenol __no treatment
__Aspirin __narcotic/pain meds __pilates other:________
__cervical collar __massage __physical therapy

14.) Have you had any procedures or surgeries to treat the neck pain? If yes, what type?

____

15.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__bone scan __MRI __plain radiographs (X-ray) other:________
__CT scan __EMG/nerve conduction study __no imaging studies

16.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __inability to attend school __working light duty
__difficulty attending school __inability to perform ADL's __working on a limited basis
__difficulty with ADL's __inability to work other:________
__difficulty with REC sports participation __requiring constant assistance
__functional limitations __requiring occasional assistance

17.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:________

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date
Recall Review Signatures:		Date:
1 ________	________	________
2 ________	________	________
3 ________	________	________
4 ________	________	________
5 ________	________	________
6 ________	________	________
7 ________	________	________