Neck Pain Questionnaire

When did your pain start?--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

How did your pain start? ie: gradual, suddenly, accident-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

If this was due to a motor vehicle accident, is ICBC involved or do you have a legal case pending?--------------------------------------------------------------------------------------------------------------- Can you describe your pain ie aching/burning ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Where is your pain? Is it located more to one side? Does it radiate anywhere?-----------------------------------------------------------------------------------------------------------------------------------------------------

Has your pain been getting better/worse/staying the same?------------------------------------------------------------------------------------------------------------------------------------------------------------------------------ What makes your pain better ex stretching, exercise, medications etc?----------------------------------------------------------------------------------------------------------------------------------------------------------------

What makes your pain worse?-----------------------------------------------------------------------------------

On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine,

How do you rate your pain on your best day----------- your worst day----------

Does your pain come and go or is it constant?------------------------------------------------------------------

In the last 24 hours, how much relief have your pain treatments or medications provided?

Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete relief

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

 **1. General Activity:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Mood:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Walking Ability:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Normal Work (includes both work outside the home and housework)**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Relations with other people:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Sleep:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Enjoyment of Life:**

 Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Do you have any numbness or tingling in your arms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

Neurological review of systems: Have you recently experienced any of the following? Please circle if you have been experiencing any of the following:

Numbness or tingling in your legs Fever Headaches

Change in bowel or bladder function Night Pain Chills

Changes in Speech/Swallowing Dizziness Loss of Hearing

Loss of balance or Coordination Loss or Change in Vision Weight loss

Any others?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In terms of your function, does your neck pain impact your..

1. Ability to read?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Ability to concentrate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Ability to drive?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Ability to sleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Ability to work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Ability to participate in recreation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried any of the following treatments? If so, were they successful?

Physiotherapy------------------------------------------------------------------------------------------------------------Chiropractor--------------------------------------------------------------------------------------------------------------

Injections----------------------------------------------------------------------------------------------------------------

Medications--------------------------------------------------------------------------------------------------------------Surgery---------------------------------------------------------------------------------------------------------------------

Acupuncture-------------------------------------------------------------------------------------------------------------

Have you had any investigations for this problem? ie CT, x-ray, MRI. Where and when?------------------------------------------------------------------------------------------------------------------------------------------

Please tell me about any medical conditions you have---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------Please list any surgeries you have had in the past---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Please list any current medications that you are on------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Please list any drug allergies-----------------------------------------------------------------------------------------

What do you do/did you do for work?----------------------------------------------------------------------------

Do you do a regular exercise program? If so, what type of exercise and how frequently?-----------------------------------------------------------------------------------------------------------------------------------------

Are you a smoker Yes or No? Have you been a smoker in the past?---------------------------------------How much alcohol would you drink in a week?-----------------------------------------------------------------

Do you use street drugs, or have you ever had problems with addiction issues?-----------------------

What are your hopes for today’s visit?----------------------------------------------------------------------------