NECK PAIN QUESTIONNAIRE

This questionnaire is designed by your doctor to answer specific questions. Please answer each question as completely as possible.

Name: _____ Date: _____

1. How long have you had neck pain?

_____

2. When did pain become severe?

_____

3. Do you know what started the pain that you suffer? [ ] Yes [ ] No
If yes, describe what started the pain.

_____

_____

_____

_____

_____

4. Did the pain begin after a work related injury? [ ] Yes [ ] No

5. Did the pain begin [ ] gradually?

[ ] suddenly?

6. Which word or words would you use to describe the pattern of your pain?

1	2	3
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

7. What does your pain feel like? Use the words below to describe your present pain. Circle ONLY those words that best describe your pain. Leave out any category that is not suitable. Use only a single word in each appropriate category - the one that applies best.

1

FLICKERING
QUIVERING
PULSING
THROBBING
BEATING
POUNDING

2

JUMPING
FLASHING
SHOOTING

3

PRICKING
BORING
DRILLING
STABBING
LANCINATING

4

SHARP
CUTTING
LACERATING

5

PINCHING
PRESSING
GNAWING
CRAMPING
CRUSHING

6

TUGGING
PULLING
WRENCHING

7

HOT
BURNING
SCALDING
SEARING

8

TINGLING
ITCHY
SMARTING
STINGING

9

DULL
SORE
HURTING
ACHING
HEAVY

10

TENDER
TAUT
RASPING
SPLITTING

11

TIRING
EXHAUSTING

12

SICKENING
SUFFOCATING

13

FEARFUL
FRIGHTFUL
TERRIFYING

14

PUNISHING
GRUELLING
CRUEL
VICIOUS
KILLING

15

WRETCHED
BLINDING

16

ANNOYING
TROUBLESOME
MISERABLE
INTENSE
UNBEARABLE

17

SPREADING
RADIATING
PENETRATING
PIERCING

18

TIGHT
NUMB
DRAWING
SQUEEZING
TEARING

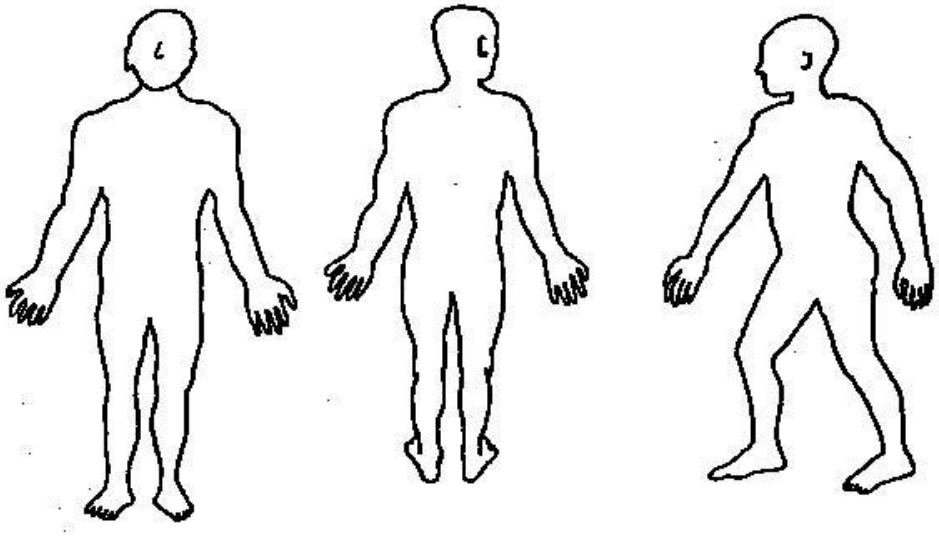
19

COOL
COLD
FREEZING

20

NAGGING
NAUSEATING
AGONIZING
DREADFUL
TORTURING

8. Use the figures below to indicate where you experienced pain.



9. Where is the worst pain? Check one only.

[ ] in the neck
[ ] in the right arm
[ ] in the left arm
[ ] in both arms
[ ] equally severe in the neck and arm/arms

10. (a) How severe is your present pain? Mark the line below.

I	1	2	3	4	5	6	7	8	9	10 I
no pain										incapacitating pain

10. (b) Circle the word that best describes your present pain.

1	2	3	4	5
mild	discomforting	distressing	horrible	excruciating

11. Standing makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

Sitting makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

Lying makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

Walking makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

Activity makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

Driving makes my pain [ ] better [ ] worse [ ] sometimes better/ sometimes worse [ ] no change

12. Do you have trouble falling asleep at night?

[ ] No (go to next question)

[ ] Yes - What keeps you from falling asleep?

How many nights a week do you have trouble falling asleep?

1	2	3	4	5
[ ]	[ ]	[ ]	[ ]	[ ]

13. Are you awakened from sleep?

[ ] No (go to next question)

[ ] Yes - What awakens you from sleep?

How many nights a week are you awakened from sleep?

1	2	3	4	5
[ ]	[ ]	[ ]	[ ]	[ ]

14. Does cold weather affect your pain?

never	occasionally	always
[ ]	[ ]	[ ]

15. Does damp weather effect your pain?

never	occasionally	always
[ ]	[ ]	[ ]

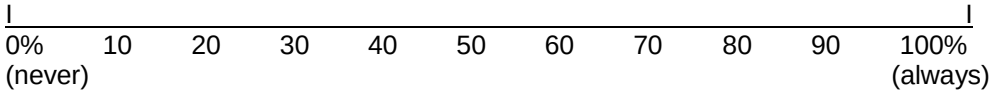
16. Is your pain improved by heat?

[ ] Yes [ ] No

17. Is your pain improved by massage?

[ ] Yes [ ] No

18. On the line below indicate how frequently you have pain.



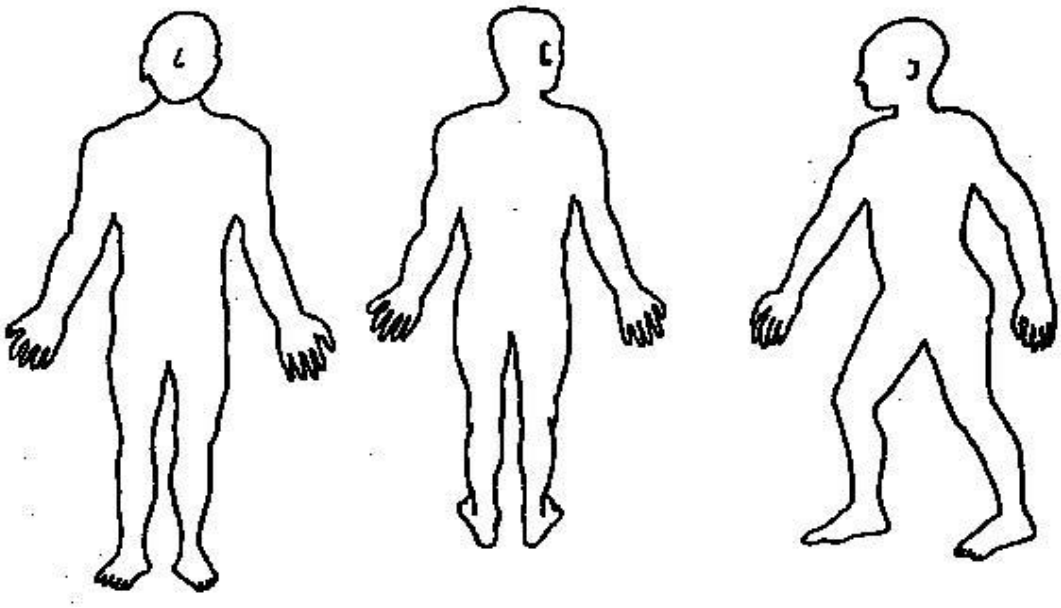
19. Overall, is your pain getting

better	worse	no change
[ ]	[ ]	[ ]

20. Do you experience numbness?

[ ] Yes [ ] No

If yes, use the figures to show where you have numbness



21. Have you noticed any weakness?

[ ] Yes [ ] No

If yes, where do you feel weak? (Be as specific as you can.) _____

22. Have you had any changes in your bowel or bladder habits recently?

[ ] Yes [ ] No

If yes, please describe these changes. (Be as specific as you can.)

_____

_____

23. Do you experience any pain when you cough or sneeze?

[ ] Yes [ ] No

If yes, where does the pain occur? (Be as specific as you can.) _____

24. Have you noticed any clumsiness in your arms, your hands, your legs, or your feet lately?

[ ] Yes [ ] No

25. What doctors have you seen about your pain and what did they do for you?

_____

_____

_____

_____

_____

26. What medications have you taken for the pain? Who gave them to you? Did they help?

MEDICATION	DOCTOR	DID IT HELP?
_____	_____	[ ] Yes [ ] No
_____	_____	[ ] Yes [ ] No
_____	_____	[ ] Yes [ ] No
_____	_____	[ ] Yes [ ] No
_____	_____	[ ] Yes [ ] No

27. Have you been treated with:

bed rest	[ ] Yes	[ ] No	[ ] helped	[ ] did not help
physical therapy	[ ] Yes	[ ] No	[ ] helped	[ ] did not help
traction	[ ] Yes	[ ] No	[ ] helped	[ ] did not help
chiropractor	[ ] Yes	[ ] No	[ ] helped	[ ] did not help

28. What x-rays have you had on your back recently? (Since your pain began.)

[ ] regular x-rays [ ] C.T. scan (cat scan) [ ] MRI

[ ] bone scan [ ] myelogram

29. Have you ever had surgery on your neck?

[ ] Yes [ ] No

If yes, what was done, who did it, and when?

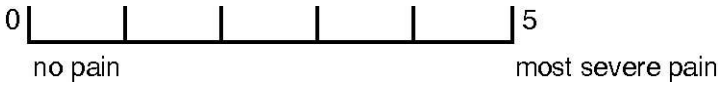
_____

_____

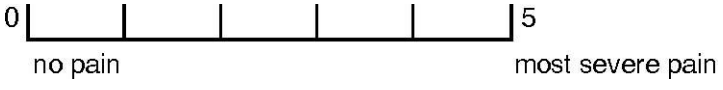
_____

30. Please place an “X” along the line to show how far from normal toward the worst possible situation your pain problem has taken you.

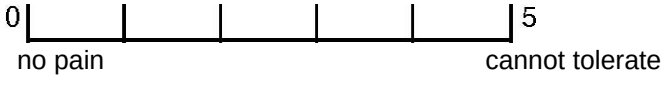
How bad is your pain today?



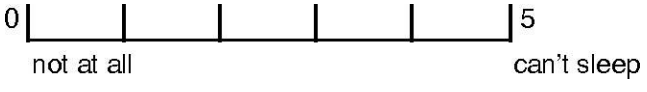
How bad is your pain on the average?



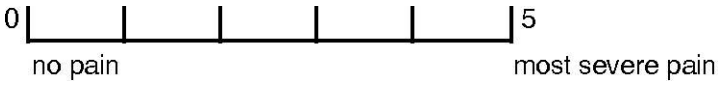
How bad is your pain at its worst?



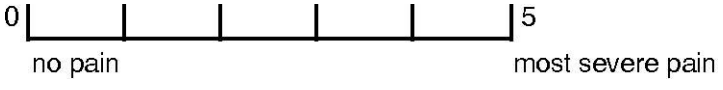
Does your pain interfere with your sleep?



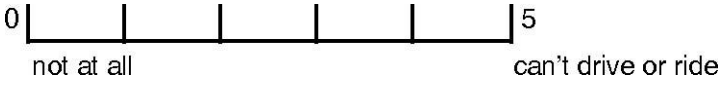
How bad is your pain with standing?



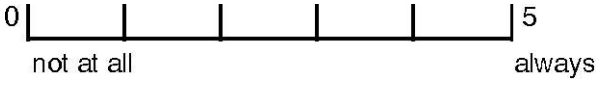
How bad is your pain with walking?



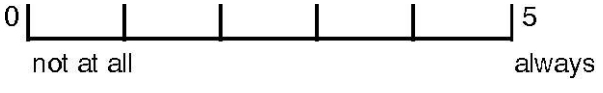
Does your pain interfere with driving or riding in a car?



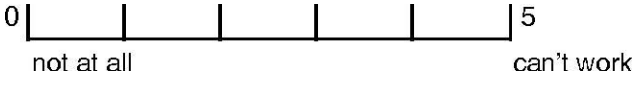
Does your pain interfere with social activities?



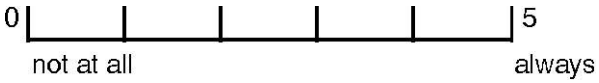
Does your pain interfere with recreational activities?



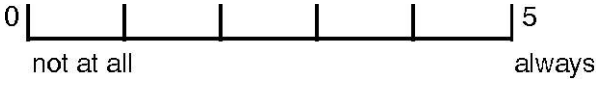
Does your pain interfere with work activities?



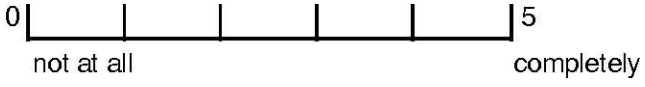
Does your pain interfere with personal care (eating, dressing, bathing, etc.)?



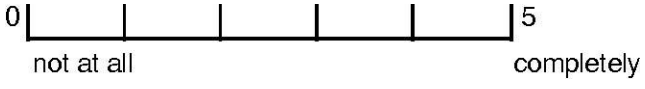
Does your pain interfere with personal relationships (family, friends, sex, etc.)?



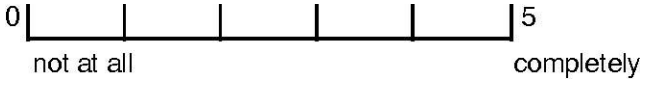
How has your pain changed your outlook on life and the future (depression, hopelessness)?



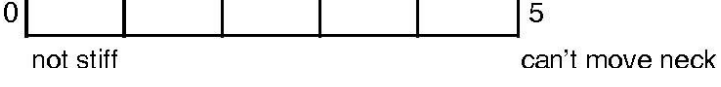
Does your pain affect your emotions?



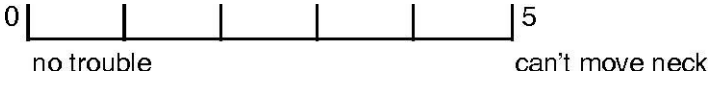
Does your pain affect your ability to think or concentrate?



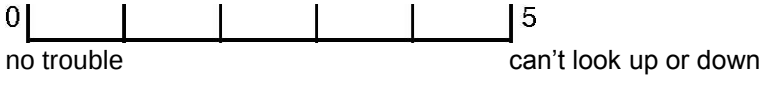
How stiff is your neck?



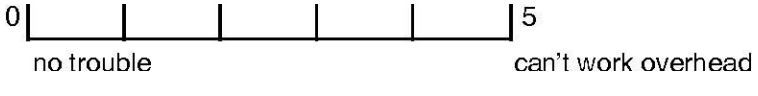
How much trouble do you have turning your neck?



How much trouble do you have looking up and down?



How much trouble do you have working overhead?



How much do pain pills help?