

## 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  
POUNING

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

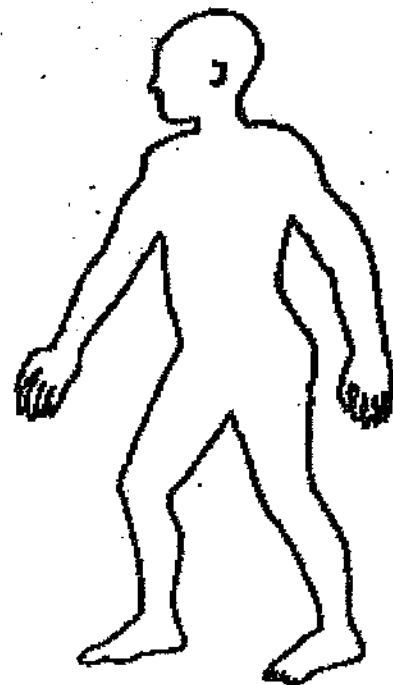
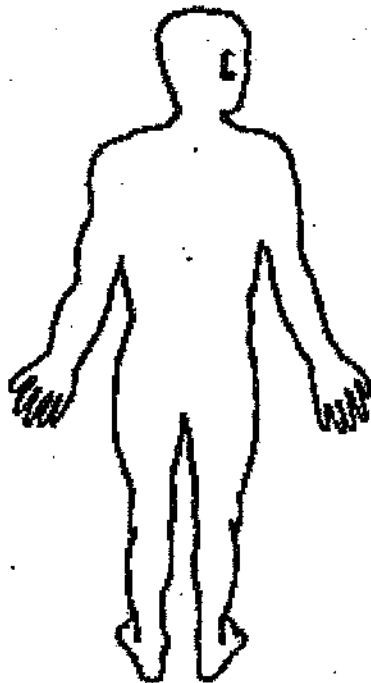
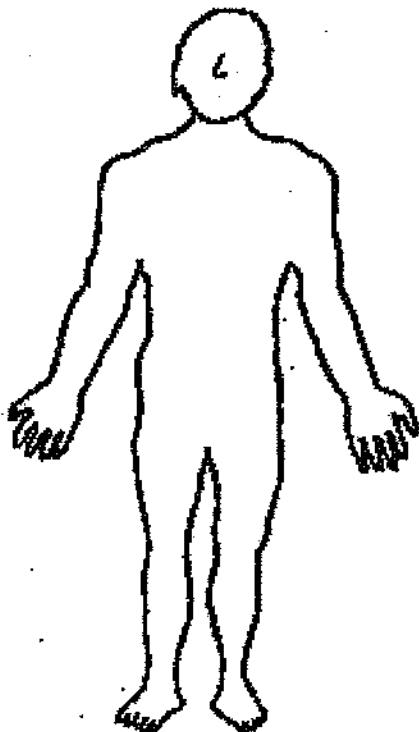
17  
SPREADING  
RADIATING  
PENETRATING  
PIERCING

18  
TIGHT  
NUMB  
DRAWING  
SQUEEZING  
TEARING

19  
COOL  
COLD  
FREEZING

20  
NAGGING  
NAUSEATING  
AGONIZING  
DREADFUL  
TORTURING

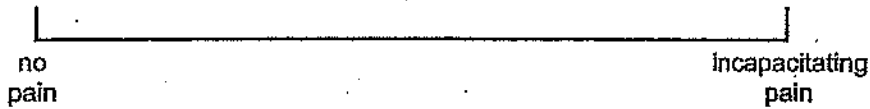
8. Use the figures below to indicate where you experienced pain.



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.



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?

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

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. Are you awakened from sleep?

No (go to next question)

Yes What awakens you from sleep?

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How many nights a week are you awakened from sleep?

1      2      3      4      5  
           

14. Does cold weather effect your pain?

never      occasionally      always  
                                           

15. Does damp weather effect your pain?

never      occasionally      always  
                                           

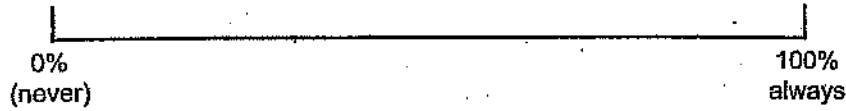
16. Is your pain improved by heat?

Yes       No

17. Is your pain improved by massage?

Yes       No

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



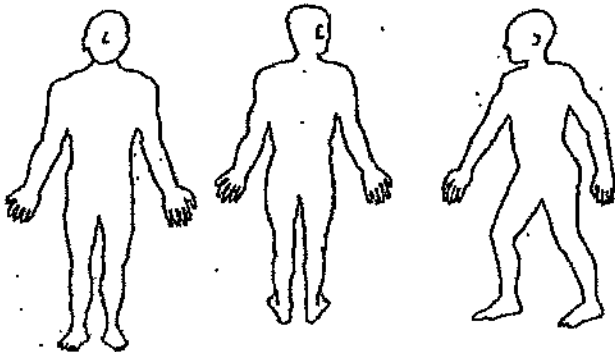
19. Overall, is your pain getting

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

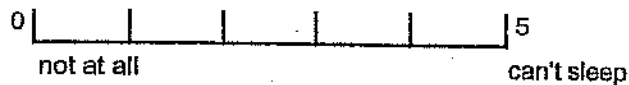
25. What doctors have you seen about your pain and what did they do for you?

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

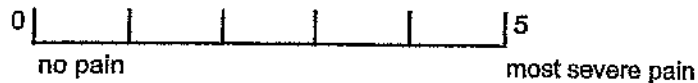
MEDICATION	DOCTOR	DID IT HELP?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No



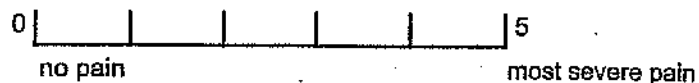
4. Does your pain interfere with your sleep?



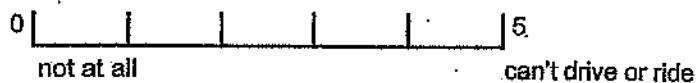
5. How bad is your pain with standing?



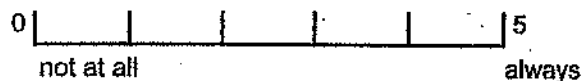
6. How bad is your pain with walking?



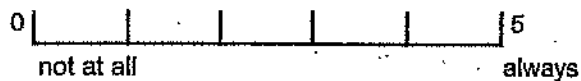
7. Does your pain interfere with driving or riding in a car?



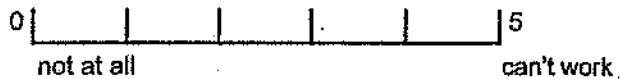
8. Does your pain interfere with social activities?



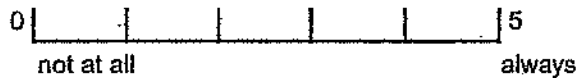
9. Does your pain interfere with recreational activities?



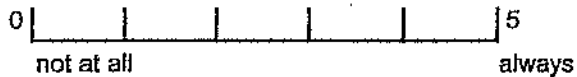
10. Does your pain interfere with work activities?



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



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



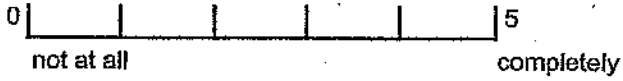
13. How has your pain changed your outlook on life and the future (depression, hopelessness)?



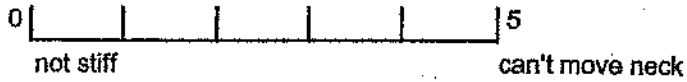
14. Does your pain affect your emotions?



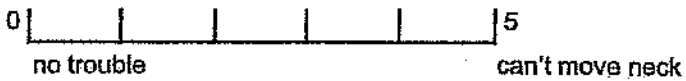
15. Does your pain affect your ability to think or concentrate?



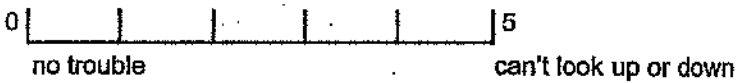
16. How stiff is your neck?



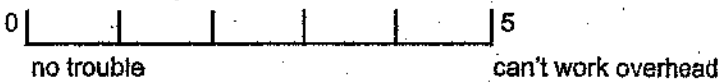
17. How much trouble do you have turning your neck?



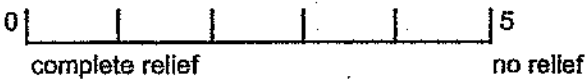
18. How much trouble do you have looking up and down?



19. How much trouble do you have working overhead?



20. How much do pain pills help?



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