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 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 1 | FLICKERING  | PINCHING  | DULL  | FEARFUL  | SPREADING  |
| 2 | JUMPING  | TUGGING  | TENDER  | CRUEL  | NUMB |
| 3 | STABBING  | HOT  | BURNING  | BLINDING  | COOL |
| 4 | SHARP  | ITCHY  | SMARTING  | INTENSE  | NAUSEATING |
| 5 | QUIVERING  | PRESSING  | SORE  | FRIGHTFUL  | RADIATING  |
| 6 | PULLING  | PRESSING  | TENDER  | CRUEL  | NUMB  |
| 7 | FLASHING  | WRENCHING  | RASPING  | KILLING  | SQUEEZING  |
| 8 | LANCINATING  | SICKENING  | TROUBLESOME  | TROUBLESOME  |  |
| 9 | PULSING  | GNAWING  | HURTING  | TERRIFYING  | PENETRATING  |
| 10 | TUGGING  | TENDER  | CRUEL  | NUMB  |
| 11 | HOT  | BURNING  | BLINDING  | COOL  |
| 12 | BORING  | SCALDING  | EXHAUSTING  | COLD  | FREEZING  |
| 13 | CRAMPING  | ACHING  | PIERCING  |  |
| 14 | CRUSHING  | HEAVY  | PUNISHING  |  |
| 15 | CRUSHING  | HEAVY  | PUNISHING  |  |
| 16 | CRUSHING  | HEAVY  | PUNISHING  |  |
| 17 | CRUNCHING  | HEAVY  | PUNISHING  |  |
| 18 | POUNDING  | TENDER  | CRUEL  | NUMB  |
| 19 | POUNDING  | TENDER  | CRUEL  | NUMB  |
| 20 | POUNDING  | TENDER  | CRUEL  | NUMB  | FREEZING  |
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 mild         2 discomforting       3 distressing       4 horrible       5 excruciating

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

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

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

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

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

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

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

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?

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOCTOR</th>
<th>DID IT HELP?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>[ ] Yes [ ] No</td>
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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?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
no pain | most severe pain

How bad is your pain on the average?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
no pain | most severe pain

How bad is your pain at its worst?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
nom pain | cannot tolerate

Does your pain interfere with your sleep?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
not at all | can’t sleep

How bad is your pain with standing?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
no pain | most severe pain

How bad is your pain with walking?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
no pain | most severe pain

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

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
not at all | can’t drive or ride

Does your pain interfere with social activities?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
not at all | always

Does your pain interfere with recreational activities?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
not at all | always

Does your pain interfere with work activities?

0 | 1 | 2 | 3 | 4 | 5
---|---|---|---|---|---
not at all | can’t work
Does your pain interfere with personal care (eating, dressing, bathing, etc.)?

0 | 1 | 2 | 3 | 4 | 5
not at all | always

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

0 | 1 | 2 | 3 | 4 | 5
not at all | always

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

0 | 1 | 2 | 3 | 4 | 5
not at all | completely

Does your pain affect your emotions?

0 | 1 | 2 | 3 | 4 | 5
not at all | completely

Does your pain affect your ability to think or concentrate?

0 | 1 | 2 | 3 | 4 | 5
not at all | completely

How stiff is your neck?

0 | 1 | 2 | 3 | 4 | 5
not stiff | can't move neck

How much trouble do you have turning your neck?

0 | 1 | 2 | 3 | 4 | 5
no trouble | can't move neck

How much trouble do you have looking up and down?

0 | 1 | 2 | 3 | 4 | 5
no trouble | can't look up or down

How much trouble do you have working overhead?

0 | 1 | 2 | 3 | 4 | 5
no trouble | can't work overhead

How much do pain pills help?

0 | 1 | 2 | 3 | 4 | 5
complete relief | no relief