NECK QUESTIONNAIRE

Patient Information

Baptist Health

THERAPY CENTER
Baptist Medical Center East
400 Taylor Road
Montgomery, Al 36124-1267
334-244-8345

PRESENT HISTORY

1. When did the pain start?_____
2. How did the pain start? _____

PAIN SCALE (CIRCLE) 0 = no pain 10 = worst pain

Please rate your highest level of pain over the past 30 days

0 1 2 3 4 5 6 7 8 9 10

Rate the level of pain in your neck today

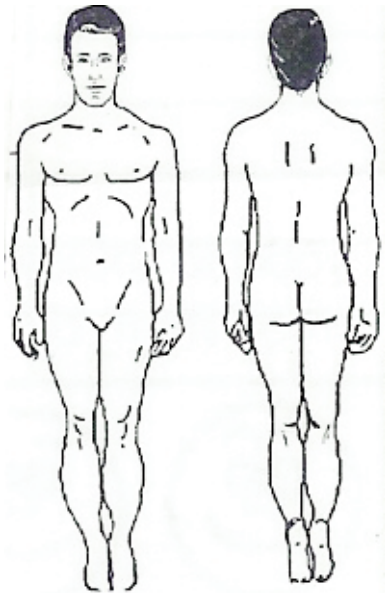
0 1 2 3 4 5 6 7 8 9 10

Rate the level of pain in your arm today (if applicable)

0 1 2 3 4 5 6 7 8 9 10

3. Where precisely did the pain start? (draw it in with an "X" on figure at right)
4. Where did it spread to? (draw it in with an "X" on figure at right)
5. Where is it now / currently today?_____
6. What makes it worse_____
7. Does it hurt at night? ❑ Yes ❑ No

7b. If yes can the pain be affected by Change in position or activity of any kind? ❑ Yes ❑ No



8. What is it like first thing of a morning? ❑ Better ❑ Stiff ❑ Sore
9. What is it like mid-day? ❑ Same ❑ Better ❑ Worse
10. What is it like late afternoon? ❑ Same ❑ Better ❑ Worse
11. What is it like in the evening? ❑ Same ❑ Better ❑ Worse
12. What have you learned that makes your neck better?: _____

_____

13. Are you currently off work because of your neck pain? ❑ Yes ❑ No If yes, since when?_____
14. Do you have any tingling, numbness or loss of skin sensation? ❑ Yes ❑ No if yes, explain: _____

_____

15. Have you experienced any clumsiness with your hands or weakness in your arm? ❑ Yes ❑ No If yes, explain:_____

_____

16. What treatments have you had? ❑ None or _____

_____

Did they help? ❑ Yes ❑ No ❑ Other: (explain)_____

17. Presently, are you getting ❑ Better ❑ Worse ❑ About the same

PREVIOUS HISTORY

18. Have you had anything similar before? ❑ Yes ❑ No If yes, describe:_____

_____

19. Please list all conditions you are currently being treated for: _____

_____

20. Please list all other medical history/complications:_____

_____

21. Please list family history of medical/health complications: _____

_____

22. Are you taking any medication? ❑ Yes ❑ No If yes describe:
23. When is your next physician visit? _____
24. What concerns you most, your pain____or restriction of activities ____both ___N/A _____
25. What are your goals in coming to me? ❑ N/A Define those functional goals: _____

_____

Patient Signature: _____

PT 990