NECK PAIN ASSESSMENT **Date:**

Personal Information:

Name:_____
(Last Name, First Name)

Birth Date:___/___/___ Age:_____
Month Day Year

Sex: ❑Male ❑Female

Marital Status: ❑Married ❑Divorced
❑ Separated ❑Single

Are You Right ❑ or Left ❑ Hand Dominant

Back Symptoms:

Where is your pain?
How long has it been there?

Location	*Duration (wks)*
❑Head	
❑Neck	
❑Shoulder (L) (R)	
❑Arm (L) (R)	
❑Hand (L) (R)	
❑Other;	

Was the onset of your present pain...
- ❑Sudden (min.) ❑Sudden (hours)
- ❑Gradual (days) ❑Gradual (weeks)
- ❑Other; ❑Unknown

What was the cause of your present pain?
- ❑Unknown ❑Hit in head or neck
- ❑Lifting ❑Auto accident
- ❑Twisting ❑Bending
- ❑Fall ❑Pulling

Do you believe your pain is related to a work injury?
- ❑No
- ❑Possible
- ❑Yes; date injured: ___/___/___

(If "Yes" please complete a Work Injury Form)

When having pain is it generally...
- ❑Mild discomfort or less
- ❑Dull pain, worse at times
- ❑Hard aching pain, frequently worse
- ❑Severe pain, sharp/shooting at times
- ❑Very severe, sharp, shooting, disabling
- ❑Extremely severe & disabling

How often are you having pain now?
- ❑ Rarely if ever
- ❑ Occasional (1-2 episodes per year)
- ❑ Recurrent (2-3 days every few months)
- ❑ Frequent (>3 days per month)
- ❑ Very frequent (every week)
- ❑ Every day

Describe your pain as;
constant *(C)* or intermittent *(I)*, and
sharp *(S)*,dull *(D)*, throbbing *(T)* or burning *(B)*.

Location	*C*	*I*	*S*	*D*	*T*	*B*
❑ Head	❑	❑	❑	❑	❑	❑
❑ Neck	❑	❑	❑	❑	❑	❑
❑ Shoulder	❑	❑	❑	❑	❑	❑
❑ Arm	❑	❑	❑	❑	❑	❑
❑ Ž Hand	❑	❑	❑	❑	❑	❑
❑ Other;	❑	❑	❑	❑	❑	❑

What time of day is your pain usually worse?
- ❑ Morning ❑ Same all day
- ❑ Mid-day ❑ At night in bed
- ❑ Evening

What makes your pain worse?
- ❑ Lying down ❑ Looking down
- ❑ Sitting ❑ Looking up
- ❑ Standing ❑ Looking (L) (R)
- ❑ Walking ❑ Sneezing
- ❑ Lifting ❑ Coughing
- ❑ Other; ❑ Sleeping

What makes your pain better?
- ❑ Lying down ❑ Looking down/up
- ❑ Sitting ❑ Looking (L) (R)
- ❑ Standing ❑ Medication
- ❑ Walking ❑ Physical therapy
- ❑ Other; ❑ Nothing

Since the onset, is your pain getting...
- ❑ Rapidly worse ❑ Rapidly better
- ❑ Slowly worse ❑ Slowly better
- ❑Unchanged

Since the onset of this episode of pain, have you noticed any of the following symptoms?

- ❑Numbness in hand; (L), (R), or Both
- ❑Numbness in arm; (L), (R), or Both
- ❑Clumbsiness of hands; (L), (R), Both
- ❑Balance problems
- ❑Bladder problems
- ❑Bowel problems
- ❑Pain that wakes you from sleep
- ❑Fever, chills, shakes, sweats

Please describe, include details and dates.

_____
_____
_____
_____
_____

Prior to the onset of this episode of pain, had you noticed any of the following symptoms?

- ❑Numbness in hand; (L), (R), or Both
- ❑Numbness in leg; (L), (R), or Both
- ❑Clumbsiness of hands; (L), (R), Both
- ❑Balance problems
- ❑Bladder problems
- ❑Bowel problems
- ❑Pain that wakes you from sleep
- ❑Fever, chills, shakes, sweats

Please describe, include details and dates.

_____
_____
_____
_____
_____

Work & Recreational Activities

Are you presently employed?

- ❑No; how long since you were?

_____
_____

- ❑Yes; where and for how long?

_____
_____

What is your occupation?

_____ (Present occupation)

_____ (Prior occupation)

_____ (Prior occupation)

Activities at home or work mostly involve;

- ❑ Manual labor, heavy lifting
- ❑ Manual labor, less strenuous
- ❑ Sitting most of the day
- ❑ Walking or standing most of the day
- ❑ House work and child care (#____ children)

How is the pain limiting your job and/or home activities?

- ❑ Not limited in any way
- ❑ Not limited much due to pain
- ❑ Able to work around the pain
- ❑ Must stop and limit activities
- ❑ Unable to work for days at a time
- ❑ Unable to work at all due to pain

Has your present episode of pain prevented you from working your regular job?

- ❑ No
- ❑ Not applicable
- ❑ Yes; how many work days missed?

_____

What activities have you enjoyed in the past that pain prevents you from enjoying today?

_____
_____
_____
_____

How much is your pain limiting your social, recreational, and other activities?

- ❑ Not limited in any way
- ❑ Not limited much due to pain
- ❑ Able to do most things with the pain
- ❑ Modify activities to control the pain
- ❑ Greatly limit activities to control pain
- ❑ Unable to participate in any activities

Evaluation & Treatment:

What other Medical/Osteopathic Doctors or Chiropractors have you seen for your problem? (List names and dates)

Doctors: _____
_____
_____

Chiropractors: _____
_____
_____

What studies have been done on your neck? (List where and when)

- ❑ None
- ❑ X-ray; _____
- ❑ CT scan; _____
- ❑ Myelogram; _____
- ❑ MRI scan; _____
- ❑ Bone scan; _____
- ❑ EMG; _____

What treatment have you received? (List by whom and when)

- ❑ None
- ❑ Manipulation; _____
- ❑ Traction; _____
- ❑ Phys. therapy; _____
- ❑ Spinal block; _____
- ❑ Hospitalized; _____
- ❑ Other; _____

Do you take medication for your pain?

- ❑ No
- ❑ Yes; list medications and dosages.

Have you had neck surgery?

- ❑ No
- ❑ Yes; list type, date and surgeon. Did it help your pain?

Past Medical History:

Please rate your general health.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

Do you have any medical problems for which you regularly see a doctor?

- ❑ No
- ❑ Yes; list doctor and problem:

Have you had surgery? (other than neck surgery)

- ❑ No
- ❑ Yes; list type, date, and surgeon:

Have you ever been seriously injured?

- ❑ No
- ❑ Yes; details/dates:

Have you ever been hospitalized?

- ❑ No
- ❑ Yes; when and why?

Do you have any allergies to medication?

- ❑ No
- ❑ Yes; list drug(s) and reaction(s):

Please list your current medications and dosages.

Have you ever been evaluated/treated for substance (drugs/alcohol) dependence?

- ❑ No
- ❑ Yes; when, where, by whom?

Have you ever been evaluated/treated for emotional or psychiatric problems?

- ❑ No
- ❑ Yes; when, where, by whom?

Did you suffer any unusual childhood illness?

- ❑ No
- ❑ Yes; what and when?

Family History:

Are there any medical problems that tend to run in your family?

- ❑ No
- ❑ Yes; list family member and condition:

Do spine problems tend to run in your family?

- ❑ No
- ❑ Yes; list family member & condition:

Any spine surgery? ❑ No ❑ Yes

Social History:

What is the highest level of education you have completed?

- ❑ Grade school
- ❑ High school
- ❑ Trade school
- ❑ College
- ❑ Graduate school

Do you like your work?

- ❑ Yes
- ❑ Not applicable
- ❑ No; why not?

Do you like your boss/supervisor?

- ❑ No
- ❑ Not applicable
- ❑ Yes

In the past have you been unable to work because of pain?

- ❑ No
- ❑ Not applicable
- ❑ Yes; how many days total?

Have you had past work related spine injuries?

- ❑ No
- ❑ Yes, list how and when.

/ /

/ /

/ /

Do you exercise on a regular basis?

- ❑ No
- ❑ Yes; doing what, how many days/week?

Do you smoke or chew tobacco?

- ❑ No
- ❑ Yes; how much?

Do you drink alcohol (beer, wine, liqueur)?

- ❑ No
- ❑ Yes; how often/much?

Have any of the following reasons caused you to be emotionally upset recently?

❑ Not upset ❑ Marital ❑ Social
❑ Work ❑ Legal ❑ Financial
❑ Other;_____

If your condition does not improve, what will your future plans include?

Do your religious beliefs prevent you from receiving blood transfusions if medically necessary?

❑ No
❑ Yes

Medical-legal Information:

Have you ever been involved in a medical law suit?

❑ No
❑ Yes; please explain.

Are you involved in a medical lawsuit now?

❑ No
❑ Yes; please explain.

Is an attorney currently involved with your neck problem?

❑ No
❑ Yes; please explain.

Review of Systems:

Please indicate if you now have (or have had in the past) problems with any of the following;

❑ Weight loss
❑ Weight gain
❑ Fever, Chills, Sweats
❑ Sleep
❑ Depression
❑ Vision
❑ Hearing
❑ Nosebleeds
❑ Dentures/caps
❑ Loose teeth
❑ Chipped teeth
❑ Jaw pain
❑ Neck pain
❑ Asthma
❑ Emphysema
❑ Bronchitis/Pneumonia
❑ Chest pain
❑ Heart attack/Heart failure
❑ Heart murmur
❑ Arrythmia
❑ High blood pressure
❑ Headaches
❑ Stroke
❑ Diabetes
❑ Thyroid disease
❑ Poor circulation
❑ Muscle cramps
❑ Hiatal hernia
❑ Stomach ulcers/Severe indigestion
❑ Liver disease/Hepatitis
❑ Gall bladder
❑ Pancreatitis
❑ Bowel disease
❑ Dark or bloody stools
❑ Pelvic pain
❑ Kidney stones/infections
❑ Bladder infections
❑ Difficult urination
❑ Lumps in breast/testis/abdomen
❑ History of cancer
❑ Arthritis or gout
❑ Seizures or fits
❑ Bleeding disorders
❑ Wound infections
❑ Anesthesia
❑ Blood transfusions ❑ AIDS/HIV

Neck Outcome Assessment:

Please indicate, by a mark on the bar below, how much pain you are presently getting from your neck on average.

0 10

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No pain Worst pain

At present, are you working?
(house wives and retired persons relate activity to previous abilities)

- ❑ Full time at usual job
- ❑ Full time at a lighter job
- ❑ Part time
- ❑ Not working

At present, can you undertake household chores or odd jobs?

- ❑ Normally
- ❑ As much as usual but slowly
- ❑ A few, not as many as usual
- ❑ Not at all

At present, can you undertake sporting or social pursuits? (e.g. dancing)

- ❑ As much as usual
- ❑ Almost as much as usual
- ❑ Some, much less than usual
- ❑ Not at all

How often have you seen a doctor or had treatment (e.g. physical therapy) for your pain?

- ❑ Never
- ❑ Rarely
- ❑ About once a month
- ❑ More than once a month

How often do you take pain killers for your pain?

- ❑ Never
- ❑ Occasionally
- ❑ Almost every day
- ❑ Several times each day

Do you have to rest during the day because of pain?

- ❑ No
- ❑ A little
- ❑ Half the day
- ❑ Over half the day

Activity level on average is best described as;

- ❑ Bedridden
- ❑ Wheelchair bound
- ❑ House bound
- ❑ Light physical activity
- ❑ Light work
- ❑ Limited medium work
- ❑ Medium work
- ❑ Heavy work with pain
- ❑ No limitation

Please mark any activities that you <u>can</u> do;

- ❑ Lift a small (3 year old) child
- ❑ Sit for half an hour
- ❑ Stand in one place for half an hour
- ❑ Travel in a car or bus for half an hour
- ❑ Walk 500 yards
- ❑ Put shoes and socks on without help.
- ❑ General home maintenance
  (i.e. vacuum, wash dishes, laundry)

Does your pain regularly disturb...

Social activities	❑ Yes	❑ No
Sexual activity	❑ Yes	❑ No
Sleep	❑ Yes	❑ No

How does pain affect the following activities?

	Severely Impossible	Moderately Difficult	Mildly Not Much	Not at all
Sleeping	❑	❑	❑	❑
Walking	❑	❑	❑	❑
Sitting	❑	❑	❑	❑
Driving	❑	❑	❑	❑
Dressing	❑	❑	❑	❑
Sex life	❑	❑	❑	❑
Work	❑	❑	❑	❑
Sports	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

PAIN SCALE:

- How much of your pain is from your neck, and how much is from your shoulder, arm, or hand.

100% ***Total*** pain = _____% ***Neck*** pain + _____% ***Shoulder, Arm, & Hand*** pain

- Please rate your pain when it is ***LEAST*** bothersome by placing a single mark on scale below.

(0= No pain) (10= Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

- Please rate your pain when it is ***MOST*** bothersome by placing a single mark on scale below.

0 1 2 3 4 5 6 7 8 9 10

PAIN DRAWING:

On the figures below please indicate where you are having any;

- Draw arrows to show where pain goes or shoots.
- Please indicate where the pain is worse.
- Be sure to show ALL areas involved.

Aching/pain	**(XXXX)**
Numbness/tingling	**(00000)**
Pins/needles	**(::::::::)**
Burning	**(/////////)**
Spasm/cramp	**(ΔΔΔΔ)**