We Care Chiropractic Center
Helping to improve your quality of life since 1985!

Neck Pain Questionaire

#:_____

Patient Name:_____ Today's Date: _____

1 Date of onset: _____

2 Location of pain: Front Back

Neck Upper Lower

Left Middle Right

( ) Worse on Left ( ) Worse on Right

Pain Levels: (10 being worst)

0 1 2 3 4 5 6 7 8 9 10

3 Since it started the pain has been:

( ) Constant ( ) Persistant

( ) Intermittant (comes and goes) ( ) Progressive (slowly getting worse)

4 Type of pain:

( ) Dull ache ( ) Burning ( ) Throbbing ( ) Sharp

( ) Deep ache ( ) Shooting ( ) Numbness ( ) Tingling

( ) Nauseating ( ) Other: _____

5 Headaches with your neck pain: Yes / No

How often?

( ) Daily

( ) ____ Times a Week

( ) ____ Times a Month

Where?

( ) Suboccipital (base of skull)

( ) Temporal

( ) Frontal

( ) Behind Eyes

6 Radiating Pain: Yes / No

A ( ) Bilaterally ( ) Right Only ( ) Left Only

B ( ) Mild ( ) Moderate ( ) Severe

C ( ) Tingling ( ) Numbing ( ) Aching

( ) Shooting ( ) Burning ( ) Other: _____

D Where does it radiate to?

( ) Trap Muscle ( ) Shoulder

( ) Upper Arm ( ) Outside ( ) Inside

( ) Elbow ( ) Forarm ( ) Thumb side ( ) Pinky side

( ) Hand ( ) Fingers: Thumb Pointer Middle Ring Pinky

7 Have you lost coordination in your arm / hand (dropping things)? Yes / No

8 Do you get an increase in pain with:

( ) Coughing ( ) Sneezing ( ) Straining with a movement

9 Do you have problems with the following?

( ) Smell ( ) Taste ( ) Balance

( ) Eyesight / Seeing spots ( ) Pain / Numbness in Face

Doctor's Notes: _____

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