Name: _____ Date: _____

Are your current complaints related to an auto accident: Yes / No If *Yes* Date: _____

Are your current complaints related to a work-related injury: Yes / No If *Yes* Date: _____

CURRENT COMPLAINTS: Neck

Does your pain radiate? Yes / No If Yes please indicate: _____

QUALITY: (circle *ALL* that apply to the above complaint)

Aching	Heavy	Spasm	Throbbing
Burning	Loss of Motion	Sharp	Tightness
Cramping	Numbness	Shooting	Weakness
Deep	Painful to Touch	Stabbing	Well-Localized Pain
Vague Constant	Piercing	Stiffness	
Dull	Radiating	Tenderness	

Pain Rating Scale

Rate your current pain on a scale of 1-10. 0 indicates no pain and 10 indicates extreme pain.

Your Rating Is: _____

SEVERITY:

(CIRCLE ONE) MILD / MODERATE / SEVERE

(CIRCLE ONE) GETTING WORSE / IMPROVING / STAYING THE SAME

(CIRCLE ONE) OCCASIONAL / INTERMITTENT / PROGRESSING / FREQUENT / CONSTANT

DURATION:

WHEN DID THE SYMPTOMS FIRST APPEAR: _____ (EXACT DATE AND YEAR IS REQUIRED)

TIMING: (circle all that apply)
What *IMPROVES* the pain:

- Bending or Stooping
- Exercise
- Getting off Feet
- Heat
- Hot Shower
- Ice
- Laying Down
- Massage
- Manipulation of Spine
- Movement
- OTC Meds
- Physical Activity
- Rest
- Sitting
- Standing
- Stretching
- Support / Brace
- Walking Up/Down Stairs
- Other: _____

TIMING: (circle all that apply)
What makes the pain *WORSE*:

- Bending or Stooping
- Computer Use
- Coughing / Sneezing
- Driving
- Exercise
- Inspiration
- Joint Use
- Laying
- Lifting
- Movement
- On Extreme Motion
- On Feet
- Physical Activity
- Pressure of Any Type
- Respiration
- Resting
- Sitting
- Sleeping
- Standing
- Straining
- Twisting
- Walking
- Walking Up / Down Stairs
- Weight Bearing

Is the pain worse in the: (circle all that apply)

- Morning Time
- End of Day
- Night Time
- Various Times

Ht: _____ inches Weight: _____ lbs.

Right or Left Handed (circle one)

Occupation: _____

Fulltime or Partime: _____

CONTEXT:
What does your condition interfere with? (circle)

- Daily Living Activities
- Normal Lifestyle
- Sleep
- Work Activities
- Recreational Activities
- Housework
- Gardening
- Other: _____

CONTEXT:
Does your condition interfere with exercise habits? No / Yes: (circle all that apply)

Basketball	Bowling	Golf	Walking Program	Tennis
Baseball or Softball	Fitness Program	Jogging or Running	Recreational Sports	Weight Training
Bicycling	General Exercise	Raquetball	Swimming	Other: _____