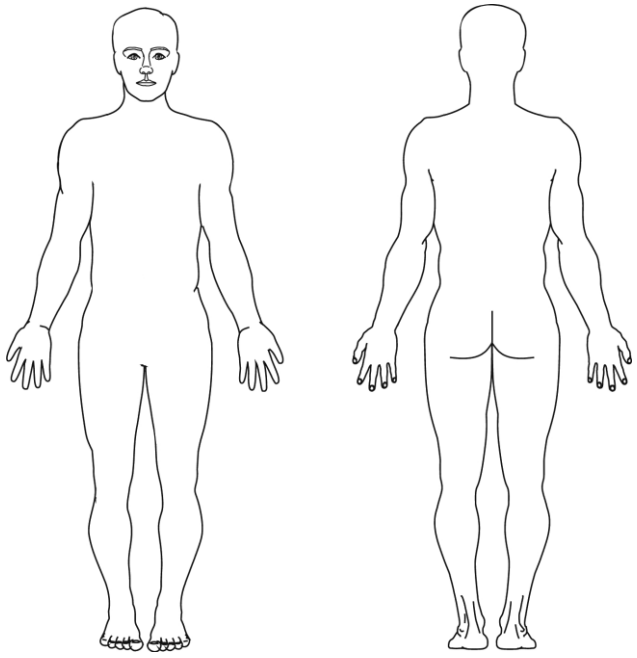
Patient Self History: Neck Pain

Date:	Time:	
Patient Name (Last, First, MI)	Date of Birth (MM-DD-YYYY)	Medical Record # (for office use)

1. When did your pain begin? (Exact date preferred) _____
2. Have you had similar symptoms before? ☐ Yes ☐ No If yes, how long ago? _____
3. Is your pain … ☐ Improving ☐ Getting worse ☐ Staying the same
4. Are your symptoms the result of an injury? ☐ Yes ☐ No (If No, skip to question 5.)
   If Yes, briefly describe your injury (how and where it occurred):

   _____
   _____
   _____

   Is this injury work related? ☐ Yes ☐ No
   Does this injury interfere with your work? ☐ Yes ☐ No
5. Using the letters below, please mark the areas on your body where you feel the described sensations.
   Please include all affected areas.
   - A = Aching
   - B = Burning
   - S = Stabbing
   - P = Pins and Needles
   - W = Weakness
   - N = Numbness



6. Using the scales below, how would you rate your average neck and arm pain in the past few days?

   No pain Extreme pain

   Neck pain: 0----------1----------2---------3----------4----------5----------6----------7----------8----------9----------10

   Arm pain: 0----------1----------2---------3----------4----------5----------6----------7----------8----------9----------10

7. What makes the pain worse? Check all that apply.

☐ Sitting	☐ Computer work	☐ Looking up	☐ Mornings
☐ Driving	☐ Turning head left	☐ Looking down	☐ Evenings
☐ Lifting	☐ Turning head right	☐ Reaching overhead	☐ Night

   What other things make your pain worse? _____

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8. What makes the pain better? Check all that apply.
   - ☐ Sitting ☐ Standing ☐ Resting arm over head
   - ☐ Lying down ☐ Walking ☐ Medication (please list): _____
   - ☐ Exercise

   What other things make your pain better? _____

9. Do you exercise regularly? ☐ Yes ☐ No

10. Do you have any of these symptoms?
    - ☐ Yes ☐ No Clumsy hands/dropping things
    - ☐ Yes ☐ No Changes in bowel/bladder control
    - ☐ Yes ☐ No Trouble walking
    - ☐ Yes ☐ No Fever or chills
    - ☐ Yes ☐ No Sweating/night sweating
    - ☐ Yes ☐ No Recent unexplained weight loss

11. Please answer the following questions.
    - ☐ Yes ☐ No Do you smoke?
    - ☐ Yes ☐ No Any history of alcohol abuse?
    - ☐ Yes ☐ No Any medication abuse?
    - ☐ Yes ☐ No Any other drug abuse?
    - ☐ Yes ☐ No Do you feel afraid to exercise?

12. Have you ever been diagnosed with any of the following?
    - ☐ Yes ☐ No Cancer: Type: _____
    - ☐ Yes ☐ No Immunosuppression
    - ☐ Yes ☐ No Osteoporosis
    - ☐ Yes ☐ No Rheumatoid or juvenile arthritis
    - ☐ Yes ☐ No Osteoarthritis: Where: _____
    - ☐ Yes ☐ No Recent infection
    - ☐ Yes ☐ No Fibromyalgia
    - ☐ Yes ☐ No Headaches/migraines
    - ☐ Yes ☐ No Other chronic pain: Where? _____
    - ☐ Yes ☐ No Anxiety
    - ☐ Yes ☐ No Insomnia
    - ☐ Yes ☐ No Depression
    - ☐ Yes ☐ No Other: _____

*****NEW PATIENTS ONLY*****

13. Have you had any previous medical tests or treatments for your neck pain?

    ☐Yes (complete table below) ☐No (skip table)

Tests			**Treatments**			
	Where	**When**		**Where**	**When**	**Was this treatment helpful?**
☐X-ray			☐Spine surgery			☐Yes ☐No
☐MRI			☐Spine injection			☐Yes ☐No
☐CT scan			☐Physical therapy			☐Yes ☐No
☐EMG (electromyogram)			☐Ice/heat			☐Yes ☐No
			☐Chiropractor			☐Yes ☐No
☐Diagnostic injections			☐Neck collar			☐Yes ☐No
☐Other:			☐Neck traction			☐Yes ☐No
			☐Massage			☐Yes ☐No
			☐Other:			☐Yes ☐No

14. Have you talked with an attorney about the cause of your neck pain? ☐ Yes ☐ No

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