

PLEASE ANSWER EVERY QUESTION!

NECK AND ARM PAIN ASSESSMENT

1. NAME: _____ DATE TODAY: _____

2. AGE: _____ SEX: _____

3. PRESENTLY EMPLOYED? _____ No _____ Yes, How long there? _____

DO YOU LIKE YOUR WORK? _____ Yes _____ No, Why Not? _____

4. PRESENT OCCUPATION: _____

PRIOR OCCUPATION: _____

Your activities at work or at home **mostly** involve:

(Check one or two) _____ Manual labor, heavy lifting most of the day

_____ Manual labor, less strenuous

_____ Sitting most of the day

_____ Walking or standing most of the day

_____ House and child care

_____ Other; Explain _____

Is your work too heavy or hard? _____ No _____ Yes; Why? _____

5. IF EMPLOYED, ARE YOU OFF WORK NOW? _____ Yes _____ No _____ N/A (Does Not Apply)

6. IF YES, WHEN WAS IT YOU LAST WORKED? (Give date): _____

7. IF YOU ARE NOT WORKING, IS IT BECAUSE OF NECK OR ARM PAIN? _____ Yes _____ No

8. DO YOU HAVE MORE PAIN IN YOUR (Check which): _____ Neck

_____ Shoulder(s) – R _____ L _____

_____ Arm(s) – R _____ L _____

9. BEFORE NOW, HAVE YOU HAD ANY PROBLEMS IN THE PAST WITH NECK OR ARM PAIN? _____ No _____ Yes;

IF NO, GO TO QUESTION 13. IF YES, GO TO NEXT QUESTION.

10. WHEN DID YOUR NECK OR ARM TROUBLE VERY FIRST START? (Check One):

_____ Started years ago, recurring or persisting since that time; give approximate date or year: _____

_____ Started within the last year or so; give date: _____

_____ Started weeks to months ago; give date: _____

11. HOW DID THE PAIN VERY FIRST START AT THAT TIME? (Check all that apply):

___ After lifting, ___ after pulling/pushing, ___ after twisting

___ After falling

___ After slipping

___ Auto accident

___ Direct blow

___ Other injury

___ Uncertain how started

___ Following some activity (coughing, straining, sports, other)

12. DID THE PAIN AT THAT TIME START? (Check One):

___ Suddenly

___ Can't remember

___ Slowly with gradual worsening

___ Does not apply

13. WHAT STARTED OR BROUGHT ON YOUR PAIN THIS TIME? (Check all that apply):

___ After lifting, ___ after pulling/pushing, ___ after twisting

___ After falling

___ After slipping

Notes:

___ Auto accident

___ Direct blow

___ Other injury

___ Uncertain how started

___ Following some activity (coughing, straining, sports, other)

14. HOW DID YOUR PAIN START THIS TIME? (Check One):

___ Sudden onset

___ Both

___ Slow onset with gradual progression

___ Not sure

15. ABOUT HOW MANY DAYS, WEEKS OR MONTHS HAS THIS CURRENT BOUT OF PAIN NOW BEEN BOTHERING YOU?

___ Days

___ Weeks (Must fill in approximate number)

___ Months

16. IS YOUR **ARM PAIN NOW** (Shoulder _____ Arm _____) (**Check One**):

- | | |
|---|--|
| <input type="checkbox"/> Gone | <input type="checkbox"/> Getting worse slowly |
| <input type="checkbox"/> Getting much better | <input type="checkbox"/> Getting worse rapidly |
| <input type="checkbox"/> Getting better slowly | <input type="checkbox"/> Getting much worse rapidly |
| <input type="checkbox"/> Staying about the same | <input type="checkbox"/> Does not apply as I don't have any arm pain |

17. IS YOUR **ARM PAIN** OR DISCOMFORT **GENERALLY** (**Check all that apply**):

- | | |
|---|--|
| <input type="checkbox"/> Sharp and shooting | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cramping or spasms | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Coldness |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Again, does not apply |

18. HAVE YOU HAD **SIMILAR ARM PAIN** IN THE PAST?

- No or Does not apply
- Yes; Constantly _____ or about how many times? _____ (**Fill In**)
- When last? _____ Which arm? _____

19. IS YOUR **NECK PAIN NOW** (**Check One**):

- | | |
|---|---|
| <input type="checkbox"/> Gone | <input type="checkbox"/> Getting worse slowly |
| <input type="checkbox"/> Getting much better | <input type="checkbox"/> Getting worse rapidly |
| <input type="checkbox"/> Getting better slowly | <input type="checkbox"/> Getting much worse rapidly |
| <input type="checkbox"/> Staying about the same | <input type="checkbox"/> Does not apply as I don't have any neck pain |

20. HAVE YOU **EVER** HAD **ANY NECK PAIN PROBLEMS** IN THE PAST?

- No
- Yes; About how many times? _____ (Fill in **approximate** number)
- When last? _____ (Give **approximate** date)

21. WAS IT EVER THIS BAD? No Yes; When? _____ (Give Dates)

22. DID IT KEEP YOU OFF OF WORK? No Yes; How-long? _____

Was it a Workers' Compensation injury? No Yes; Explain _____

23. IF THE PAIN HAS TENDED TO COME AND GO HAVE THE ATTACKS BECOME MORE FREQUENT AND MORE EASILY BROUGHT ON? (Check One):

 Yes Notes:

 No

 Attacks remaining about the same in frequency

 Pain is constant

 Does not apply

24. ARE THE ATTACKS LASTING LONGER AND BECOMING MORE DISABLING TO YOU? (Check One):

 Yes; About how long do they usually last? _____

 No

 Attacks remaining about the same in severity and duration

 Again, this does not apply

25. SINCE YOUR PAIN STARTED, FILL IN APPROXIMATE NUMBER OF TOTAL DAYS OFF WORK (OR UNABLE TO DO HOUSEWORK) DURING THE LAST:

3 weeks → days _____

6 months → days _____

6 weeks → days _____

12 months → days _____

(IF NO DAYS OFF, _____ **Check**)

3 months → days _____

24 months → days _____

If you are off work now, give date you last worked: _____

26. HOW MANY **DOCTORS** AND **CHIROPRACTORS** HAVE YOU SEEN FOR THIS PROBLEM?

Doctors (Give names, dates):

Chiropractors (Give names, dates):

27. HAVE YOU HAD MANIPULATIONS OR ADJUSTMENTS? No Yes: How Many? _____

By Whom? _____ Did they help? _____

28. ANY PHYSICAL THERAPY TREATMENTS? No Yes; _____ (Fill in number)

Are you doing any neck exercises now? No Yes

Have you ever worn a neck brace or collar? No Yes;

What period of time? _____

Are you using any neck traction? No Yes; Does it help? No Yes

29. HAVE YOU HAD SPINAL BLOCKS (EPIDURALS) FOR THIS PROBLEM ___ No ___ Yes;

How many? ___ Any help? _____

By Whom? _____ When? _____

30. HAVE YOU EVER BEEN HOSPITALIZED FOR NECK OR ARM PAIN? ___ No ___ Yes; If yes, give:

Dates

Doctors

Hospitals

31. HAVE YOU EVER HAD A MYELOGRAMS?

___ Total Number; When was your myelogram (last myelogram) done?

Give date: _____ Where? _____

32. WHAT PAIN AND/OR NERVE MEDICINE(S), INCLUDING ASPIRIN, TYLENOL AND OTHER PAIN RELIEVERS HAVE YOU BEEN TAKING? (BOTH PRESCRIPTION AND NON PRESCRIPTION)

___ None ever; ___ None now: was taking (list): _____

33. DID YOU HAVE A HAPPY CHILDHOOD ___ Yes ___ No;

If not, did you suffer: Physical and/or sexual abuse? ___ Yes ___ No

Abandonment and/or emotional neglect or abuse? ___ Yes ___ No

One or both parents alcoholic and/or drug users? ___ Yes ___ No

Parents separating and/or divorcing? ___ Yes ___ No

34. HAVE YOU EVER BEEN EVALUATED FOR MENTAL OR EMOTIONAL PROBLEMS?

___ No ___ Yes; Were you ever hospitalized for these problems? ___ No ___ Yes;

When, Where & Why? _____

NECK PROBLEMS IN THE PAST

THE FOLLOWING 4 QUESTIONS ARE ABOUT ANY NECK PROBLEMS YOU MAY HAVE HAD IN THE PAST. THEY AID US IN HELPING YOU. WE UNDERSTAND THAT THIS IS DIFFICULT. PLEASE CHOOSE THE ONES THAT MOST CLOSELY DESCRIBE ANY NECK TROUBLE YOU MIGHT HAVE HAD PRIOR TO THIS OCCURENCE OF NECK PAIN

35. IN THE PAST FEW YEARS (NOT SINCE PAIN STARTED THIS TIME), HOW OFTEN HAVE YOU HAD NECK PAIN? (Check **One Only**):

- No problems, or rarely had neck pain until this occurrence
- Occasional neck pain (once or twice per year or less)
- Recurrent neck pain (a few days every few months or more often)
- Frequent neck pain (a few or more days at least every month)
- Very frequent neck pain (every week or more often; almost every day)
- Neck pain every single day (Was it constant? Yes ___ No ___)

36. WHEN HAVING NECK PAIN IN THE PAST, HAS IT BEEN GENERALLY? (Check **One Only**):

- A mild discomfort or less
- A dull pain, worse at times
- A harder aching pain, frequently worse at times
- A severe pain, even sharp and shooting at times
- A very severe pain, frequently sharp, shooting and disabling
- An extremely severe and disabling pain

37. WHEN HAVING NECK PAIN IN THE PAST FEW YEARS, HOW HAS IT GENERALLY LIMITED YOUR JOB AND/OR HOUSEWORK? (Check **One Only**):

- Not limited in any way; haven't had neck pain until this occurrence
- Neck pain had not been bad enough to really limit me very much
- Have been able to work with neck pain all the time, but most by modifying my activities to do so
- Had to often stop and greatly limit many or most activities, but able to work most of the time
- Frequently was unable to work for several or more days at a time due to neck pain
- Unable to work at all - totally disabled by neck pain (Since when? _____)

38. WHEN HAVING NECK PAIN IN THE PAST FEW YEARS, HOW HAS IT GENERALLY LIMITED YOUR SOCIAL AND OTHER LEISURE ACTIVITIES? (Check **One Only**):

- Not limited in any way now
- Neck pain had not been bad enough to really limit me very much until this occurrence
- Have been able to do most things I like to do even with neck pain
- Had to modify activities a lot to control neck pain and not do most things
- Had to greatly limit all activities to control my neck pain and not do some things
- Was unable to engage in any of these activities whatsoever due to neck pain

NECK AND ARM PAIN ASSESSMENT

Again, do you have more pain in your:

NECK _____ R _____ L _____
SHOULDERS(S) _____ R _____ L _____
ARM(S) _____ R _____ L _____
OTHER _____

If you have been off work, give:

Date returned to some work: _____ Full Duties: _____

Please indicate if you are Still Off Work, Unemployed and/or On Disability. (Check which one)

Please answer the following 4 questions about your pain as best you can. We understand that this is difficult. Choose the responses that most closely describe your pain presently.

39. HOW **OFTEN** ARE YOU HAVING PAIN **NOW**? (✓ **One**):

- No pain or rarely have pain now
- Occasional pain (about once or twice per year or so)
- Recurrent pain (a few days ever few months or more often)
- Frequent pain (a few or more days at least every month if not more)
- Very frequent pain (every week or more often; almost every day)
- Pain every single day (Is this constant? Yes No)

40. WHEN HAVING PAIN, IS IT **GENERALLY** (✓ **One**):

- A mild discomfort or less
- A dull pain, worse at times
- A harder aching pain, frequently worse at times
- A severe pain, even sharp and shooting at times
- A very severe pain, frequently sharp, shooting and disabling
- An extremely severe and disabling pain

41. HOW IS THE PAIN **NOW** LIMITING YOUR **JOB AND/OR HOUSEWORK**? (✓ **One**):


- Not limited in any way now
- Pain not bad enough to really limit me very much now
- Able to work with pain all the time by modifying my activities
- Must stop and limit activities, but able to work most of the time
- Frequently unable to work for several or more days at a time
- Unable to work at all - totally disabled by pain

42. HOW IS PAIN **NOW** LIMITING YOUR **SOCIAL, RECREATIONAL AND OTHER ACTIVITIES**? (✓ **One**):

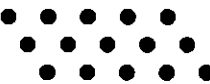
- Not limited in any way now
- Pain not bad enough to really limit me very much
- Able to do most things most of the time even with pain
- Must modify activities to control pain and not do some things
- Must greatly limit activities to control pain and not do most things
- Unable to engage in any of these activities whatsoever due to pain

PAIN DRAWING – VERY IMPORTANT!

Show by marking and drawing on the front and back of the figures below where you are having any:

Aching and/or pain 

Numbness and/or tingling 

Pins and/or needles 

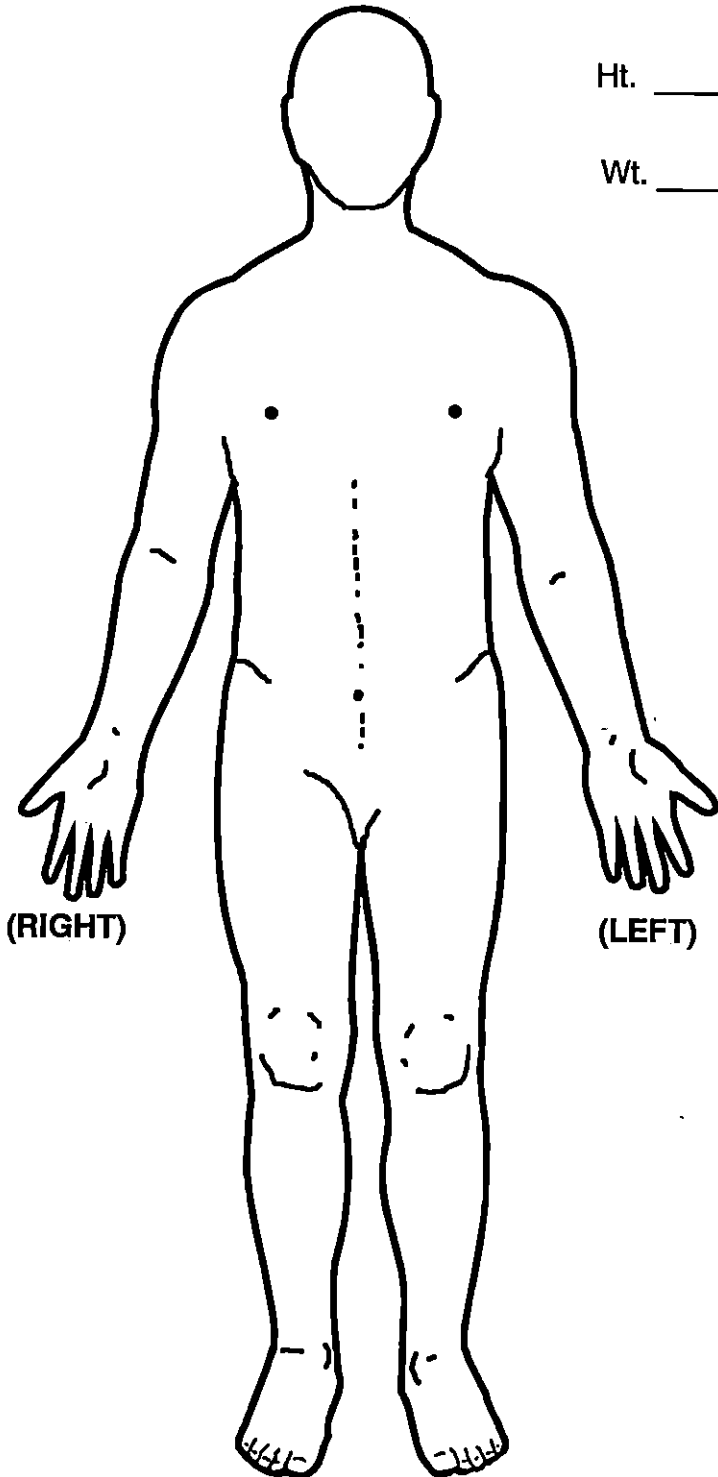
Burning 

Spasms and/or cramps 

(Draw arrows or indicate where pain goes or shoots. Show all areas involved)

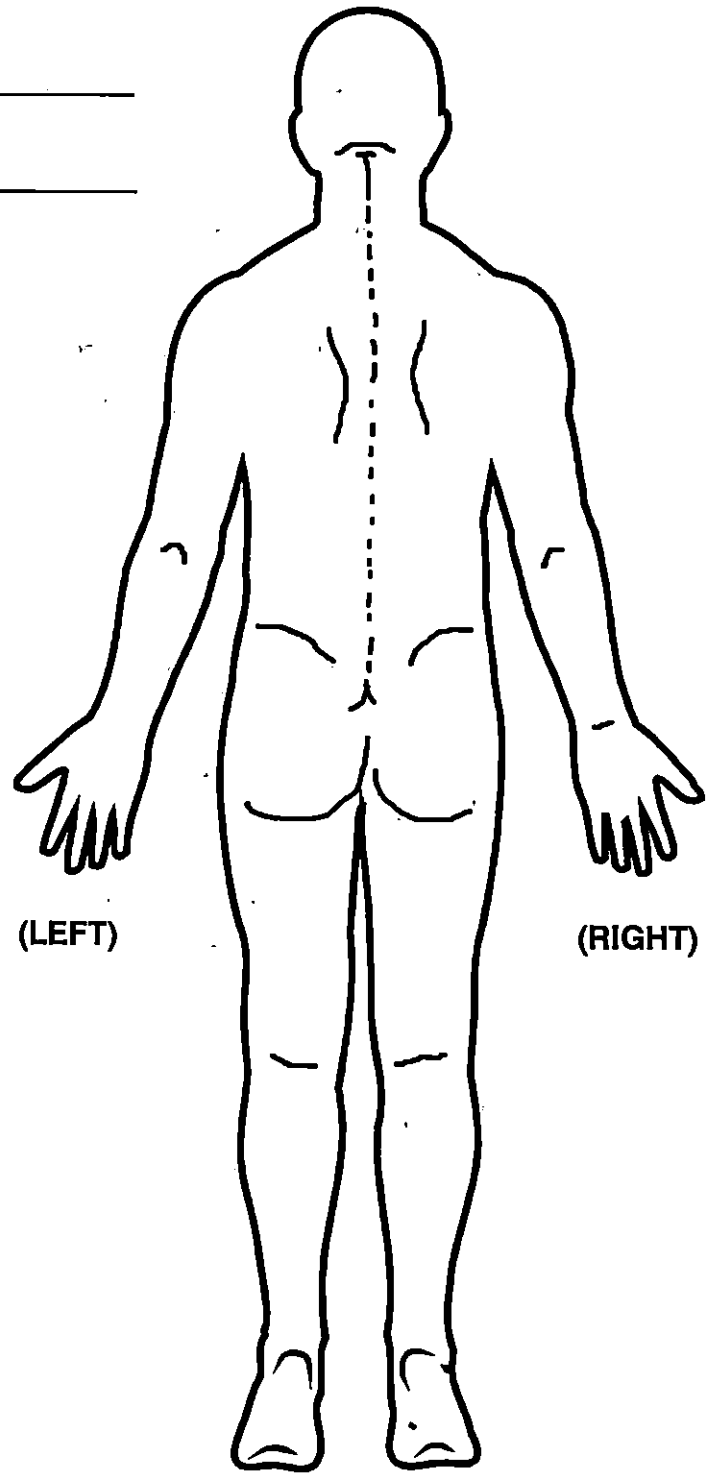
FRONT

BACK



Ht. _____

Wt. _____



Please mark or indicate where the pain is worse now

PLEASE ANSWER!!

USING A SCALE OF ZERO TO TEN, CIRCLE YOUR LEVEL OF PAIN WHEN IT IS A GOOD DAY AND WHEN IT IS A BAD DAY. (CHECK ONLY ONE NUMBER IN EACH COLUMN).

GOOD DAY

BAD DAY

DEFINITIONS OF PAIN LEVEL

___ 0

___ 0

_____ No pain.

___ 1

___ 1

_____ Mild pain or discomfort that I am sometimes aware of.

___ 2

___ 2

_____ Dull pain that I can tolerate without medication.

___ 3

___ 3

_____ Moderate pain, worse at times that I can mostly tolerate without pain medication

___ 4

___ 4

_____ Harder aching pain, frequently worse at times (medication often required).

___ 5

___ 5

___ 6

___ 6

_____ More severe pain. Pain medication required.

___ 7

___ 7

___ 8

___ 8

_____ Very severe pain.

___ 9

___ 9

___ 10

___ 10

_____ Extreme pain, most severe pain.

43. WHICH OF THE FOLLOWING SEEM TO MAKE THE PAIN OR PROBLEM A LOT **WORSE**?

- | | |
|--|---|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Getting in or out of cars and chairs |
| <input type="checkbox"/> Exercise (after) | <input type="checkbox"/> Driving a car |
| <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Prolonged standing | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Arching backwards | <input type="checkbox"/> Straining at stool |
| <input type="checkbox"/> Bending over forwards | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Bending to the right side | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Bending to the left side | <input type="checkbox"/> Putting on socks, stockings and/or shoes |
| <input type="checkbox"/> Twisting to the right | <input type="checkbox"/> Weather changes (rain, etc.) |
| <input type="checkbox"/> Twisting to the left | <input type="checkbox"/> Heat <input type="checkbox"/> Cold |
| <input type="checkbox"/> Walking (at first) | <input type="checkbox"/> Resting <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Walking (later on) | <input type="checkbox"/> Other things: List _____ |

Notes:

Do you get cramping or aching in your calf(s) when walking? No Yes;

What must you do to get relief? _____

Has your walking gotten more and more limited? No Yes;

How far can you walk now without stopping? _____

Are you getting more unsteady when you walk? No Yes N/A

46. WHICH OF THE FOLLOWING SEEM TO MAKE THE PAIN OR PROBLEM **BETTER**?

- | | |
|---|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Neck Collar |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Neck traction |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Injection for pain |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Pain pills |
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Muscle relaxers |
| <input type="checkbox"/> Exercise (after) | <input type="checkbox"/> Aspirin or anti-inflammatory pills |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Other medications |
| <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Manipulations | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Lying flat on back | <input type="checkbox"/> Other things: List _____ |

47. IS THE PAIN **GENERALLY MOST SEVER** WHEN YOU ARE (**Check one**):

Active Inactive Makes no difference

48. HOW LONG (MINUTES, HOURS OR UNLIMITED) CAN YOU?

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Lie down in one position | <input type="checkbox"/> Walk |
| <input type="checkbox"/> Sit in one position | <input type="checkbox"/> Shop |
| <input type="checkbox"/> Stand in one position | <input type="checkbox"/> Drive |

49. IS THE PAIN **USUALLY** WORSE (Check the **one** that fits you best):

In the morning when you first get up In the evening

As the day progresses At night in bed

50. DO YOU WAKE UP BECAUSE OF PAIN? No Yes; What must you do to get relief? _____

51. DO YOU HAVE TROUBLE SLEEPING? No Yes; Why? _____

52. DO YOU GET LEG CRAMPS AT REST? No Yes; Mostly during the **day** or **night**?

53. ANY OTHER JOINTS HURT? (**Describe**):

54. HAVE YOU **GAINED** ANY WEIGHT RECENTLY? No Yes; **HOW MUCH**? _____

55. HAVE YOU **LOST** ANY WEIGHT RECENTLY? No Yes; **HOW MUCH**? _____

56. HAVE YOU HAD ANY **BLADDER** PROBLEMS? No Yes; What? _____

57. HAVE YOU HAD ANY **BOWEL** PROBLEMS? No Yes; What? _____

58. ANY PROBLEMS WITH PERIODS? (**Women**) No Yes; What? _____

59. DO YOU HAVE ANY REASONS TO BE EMOTIONALLY UPSET? No Yes; What? (**Please check and explain**)

Financial

Work

Comments:

Marital

Legal

Social

Other

60. DO YOU HAVE ANY ADDITIONAL INFORMATION THAT WOULD BE HELPFUL IN UNDERSTANDING YOUR PROBLEM?

Equipment –

Gait –

- Toes
- Heels
- Unsteadiness

Neck –

- Tender
- Spasm

- ROM – Flexes to

- Extension –
- Rt. bend –
- Lt. bend –
- Rt. Rotation –
- Lt. Rotation –

PAIN

Most	More	Less	Much	Moderate	Little
Most	More	Less	Much	Moderate	Little
Most	More	Less	Much	Moderate	Little
Most	More	Less	Much	Moderate	Little
Most	More	Less	Much	Moderate	Little
Most	More	Less	Much	Moderate	Little

Neuro – Motor:

- DTR's: Biceps –
- Knees –

- Triceps –
- Ankles –

- Sensory:
- Proprioception:
- Hoffmann's:
- Babinski's:
- Clonus

Atrophy – Shoulder(s)

- Arm(s)
- Hand(s)

Pulses –

Adson's test –