



**NECK PAIN QUESTIONNAIRE**  
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female Occupation: \_\_\_\_\_

Job description: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

RIGHT HANDED

LEFT HANDED

Major complaint: \_\_\_\_\_

1. How long have you had neck pain? \_\_\_\_\_

2. Do you get arm pain?  Yes  No

Which arm gives you pain?  Right  Left  Both

Which arm is worse?  Right  Left  Both

3. Date your present pain began? \_\_\_\_\_

4. Describe the mechanism of injury or how the pain began: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**5. If the injury was from an automobile accident:**

Date of the accident? \_\_\_\_\_

Were you the driver or a passenger? \_\_\_\_\_

Were you wearing a seat belt?  Yes  No

How was your car hit?  Struck from behind  Right side  Left side  Head-on

How fast was your car traveling? \_\_\_\_\_

How fast was the other car traveling? \_\_\_\_\_

How much damage was done to your car? \$ \_\_\_\_\_

6. Is your pain getting?  Better  Worse  Staying the Same

7. Have you ever had neck problems before? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

8. Do you have any of the following?

Dropping of objects  Weakness in the arm  Loss of control of the arm  Loss of balance

Other: \_\_\_\_\_

9. Have you had trouble starting or holding your urine?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you had trouble starting or holding your bowels?  Yes  No

If yes, please describe: \_\_\_\_\_

**10. Prior treatments for your neck:**

What physicians have you seen for your neck? \_\_\_\_\_

Have you used any of the following? If yes, please describe:

Anti-inflammatory?  Yes  No \_\_\_\_\_

Muscle relaxants?  Yes  No \_\_\_\_\_

Pain killers?  Yes  No \_\_\_\_\_

Have you had any of the following treatments?

Physical therapy  Exercise program  Epidural blocks or injections

Soft collar  Hard collar  TENS unit  Chiropractic  Bed rest

Other: \_\_\_\_\_

Have you had neck surgery?  Yes  No If yes, how many times? \_\_\_\_\_

Please provide information about your neck surgeries:

Type of operation	Date	Doctor's name and city	Duration of improvement	Returned to work for how long?

**Please rate your pain overall:**

1	2	3	4	5	6	7	8	9	10
<i>No Pain</i>			<i>Moderate Pain</i>				<i>Severe Pain</i>		

11. What activities make the pain worse?

Sitting  Walking  Standing  Riding in a Car  Coughing

Sneezing  Lifting  Bending forward  Bending backward

Other: \_\_\_\_\_

12. What activities reduce the pain?

Lying down  Hot baths  Brace  Heat  Massage

Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

13. Are there any activities you can *not* do because of your pain?

- Dress without assistance
- Go out socially
- Fix a meal independently
- Lift
- Make a bed
- Grocery shop
- Walk around a mall
- Vacuum
- Carry a laundry basket
- Shovel snow
- Push a lawnmower
- Participate in sports
- Other: \_\_\_\_\_

14. About your work:

Have you missed work due to your pain?  Yes  No

Are you currently working?  Yes  No If yes, are you on:  Light duty  Regular duty

If you are not back to work, what date did you last work? \_\_\_\_\_

15. Have you had any of the following diagnostic studies?

- X-rays  Yes  No If yes, when? \_\_\_\_\_
- MRI  Yes  No If yes, when? \_\_\_\_\_
- CAT Scan  Yes  No If yes, when? \_\_\_\_\_
- Myelogram  Yes  No If yes, when? \_\_\_\_\_
- EMG  Yes  No If yes, when? \_\_\_\_\_
- Discogram  Yes  No If yes, when? \_\_\_\_\_

Do the following apply?

16. Workers' compensation?  Yes  No  Applying

17. Legal proceedings?  Yes  No  Pending

18. Disability?  Yes  No  Applying

19. If an attorney is involved, please provide the following information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Medical History** (please check all that apply)

**Major illnesses?**  Yes  No

- |  |  |                                |  |
|--|--|--------------------------------|--|
| Diabetes (Insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems (explain below) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (TB)              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer (explain below)   | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS (HIV or ARC)              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema / Bronchitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid (low or high)          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma / Shortness of Breath   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidneys                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach ulcers   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clots  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other: _____   |  |                                |  |

Patient's Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Please list any family member having any of the diseases listed above, and also list what disease they had:

Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Siblings: \_\_\_\_\_  
Grandparents: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgeries that you have had that were *not* for your neck:

\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_

List all medications that you currently take:

\_\_\_\_\_ Dosage: \_\_\_\_\_  
\_\_\_\_\_ Dosage: \_\_\_\_\_  
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\_\_\_\_\_ Dosage: \_\_\_\_\_

List your allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to metals?  Yes  No

Patient's Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Have you ever smoked cigarettes?  Yes  No Number of packs per day: \_\_\_\_\_

If you quit, when? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No How much? \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed  Separated

How many children do you have? \_\_\_\_\_

What is your level of education?

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Grade school     | <input type="checkbox"/> High school | <input type="checkbox"/> Vocational School  |
| <input type="checkbox"/> Technical school | <input type="checkbox"/> College     | <input type="checkbox"/> Graduate education |

List your sports activities and your hobbies: \_\_\_\_\_

Employment:  Full time  Part time Hours per week: \_\_\_\_\_  Retired

Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_

Please check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fevers         | <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Diarrhea                        |
| <input type="checkbox"/> Chills         | <input type="checkbox"/> Loss of energy      | <input type="checkbox"/> Blood in stools                 |
| <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Urinary burning                 |
| <input type="checkbox"/> Weight loss    | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Urinary discharge               |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Headaches                       |
| <input type="checkbox"/> Eye problems   | <input type="checkbox"/> Cough               | <input type="checkbox"/> Change in appetite              |
| <input type="checkbox"/> Ear problems   | <input type="checkbox"/> Breathing trouble   | <input type="checkbox"/> Sleeping difficulty             |
| <input type="checkbox"/> Nosebleeds     | <input type="checkbox"/> Breast mass         | <input type="checkbox"/> Problems tolerating hot or cold |
| <input type="checkbox"/> Sinus trouble  | <input type="checkbox"/> Breast discharge    | <input type="checkbox"/> Need to see a psychiatrist      |

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### For Women:

Date of last normal menstrual cycle: \_\_\_\_\_

Irregular?  Yes  No Age of menopause: \_\_\_\_\_

If postmenopausal or ovaries have been removed, are you on an estrogen supplement?

Yes  No Date of ovary removal: \_\_\_\_\_

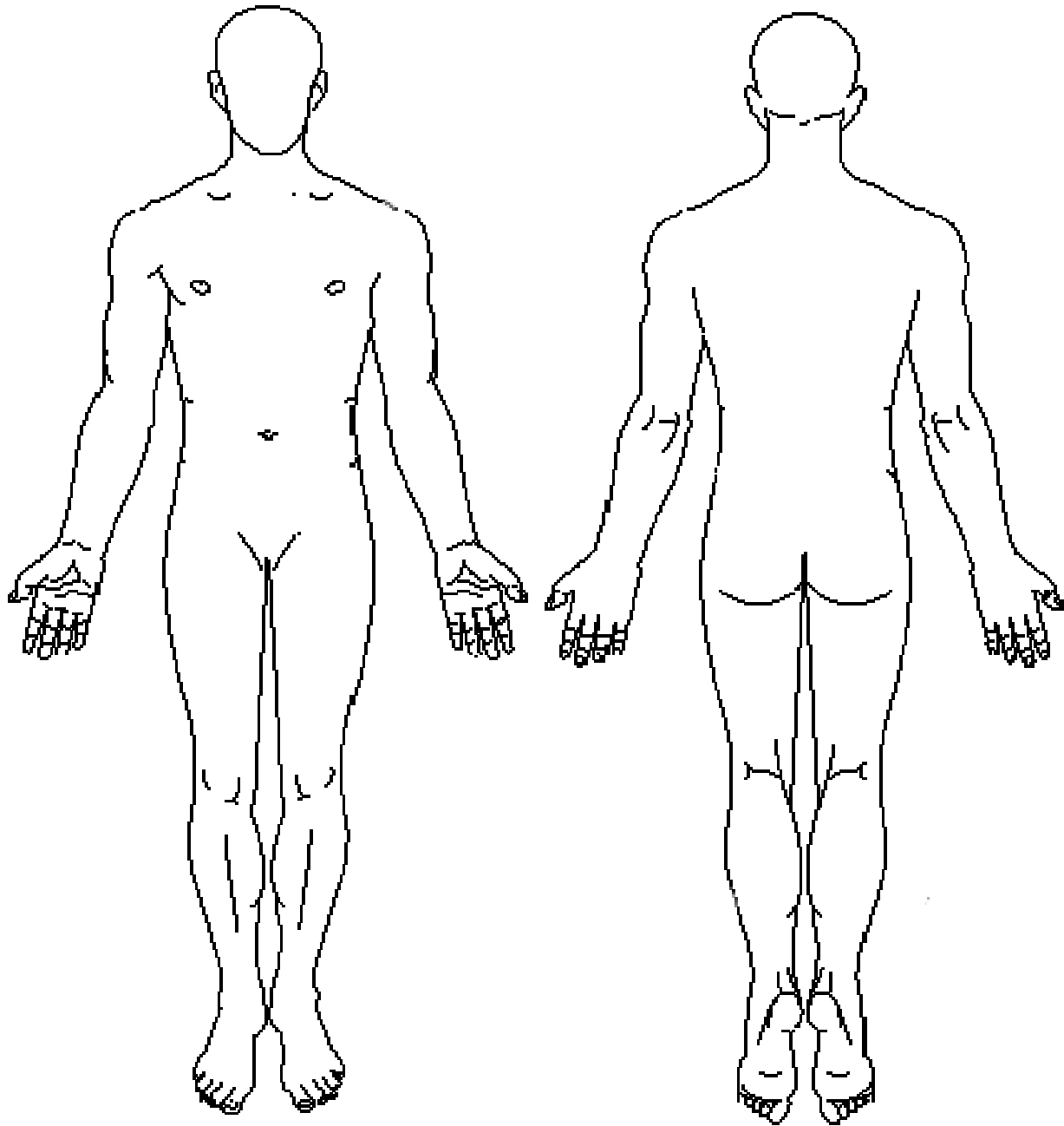
Have you had a bone density test?  Yes  No

Have you taken Estrogen in the past?  Yes  No If yes, how long? \_\_\_\_\_

Are you taking any of the following?

- |           |                              |                             |
|-----------|------------------------------|-----------------------------|
| Calcium   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vitamin D | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fosamax   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Actonel   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Boniva    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient's Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_




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## Symptoms

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Using the following keys, indicate on the drawing the location and type of pain or abnormal sensations you are experiencing:

- |                       |              |                         |                  |
|-----------------------|--------------|-------------------------|------------------|
| <b>xxxxxxxxxxxxxx</b> | Numbness     | <b>oooooooooooo</b>     | Pins and Needles |
| <b>vvvvvvvvvvvvvv</b> | Burning Pain | <b>////////////////</b> | Stabbing Pain    |
| <b>_____</b>          | Aching Pain  |                         |                  |

Patient's Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_