Patient Name: _____ Today's Date: _____

Birthdate: _____

Neck Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of what is bothering you, what part of your spine bothers you and how it happened)

_____

_____

_____

What is the location of your symptoms: ☐ None

☐ Right Front of Neck ☐ Right Side of Neck ☐ Right Back of Neck ☐ Right Arm ☐ Right Shoulder
☐ Left Front of Neck ☐ Left Side of Neck ☐ Left Back of Neck ☐ Left Arm ☐ Left Shoulder
☐ Bilateral Front of Neck ☐ Bilateral Side of Neck ☐ Bilateral Back of Neck ☐ Both Arms ☐ Both Shoulders

Check any areas of your body that your neck symptoms radiate to: ☐ None

☐ Right Upper Arm ☐ Right Shoulder ☐ Right Hand ☐ Right Forearm
☐ Left Upper Arm ☐ Left Shoulder ☐ Left Hand ☐ Left Forearm
☐ Both Upper Arms ☐ Both Shoulders ☐ Both Hands ☐ Both Forearms

Are your symptoms: ☐ Recurring ☐ Improving ☐ Worsening

What is the severity of your symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
☐ Other _____

How often do your symptoms occur: ☐ Constantly ☐ Daily ☐ Weekly ☐ Randomly
☐ Other _____

Select the quality/description of your neck symptoms: ☐ None

☐ Ache ☐ Numbness
☐ Sharp ☐ Shooting ☐ Weakness ☐ Other _____

Check all activities that aggravate your neck symptoms: ☐ None

☐ Lifting ☐ Rotation/turning head
☐ Driving ☐ Flexion (looking down) ☐ Extension (looking up) ☐ Other _____

Check all items that make your neck symptoms better: ☐ None

☐ Exercise ☐ Movement ☐ Lying Down ☐ Pain Meds/Drugs ☐ Rest ☐ Changing Position
☐ Heat ☐ Stretching ☐ Ice ☐ Over the counter medications
☐ Other _____