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):**

_____Gone
_____Getting much better
_____Getting better slowly
_____Staying about the same
_____Getting worse slowly
_____Getting worse rapidly
_____Getting much worse rapidly
_____Does not apply as I don't have any leg pain

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

_____Sharp and shooting
_____Cramping or spasms
_____Pins and needles
_____Numbness
_____Tingling
_____Burning
_____Throbbing
_____Aching
_____Coldness
_____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):**

_____Gone
_____Getting much better
_____Getting better slowly
_____Staying about the same
_____Getting worse slowly
_____Getting worse rapidly
_____Getting much worse rapidly
_____Does not apply as I don't have any leg 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 <u>One</u>):**

☐ 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 <u>One</u>):**

☐ 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 <u>TOTAL DAYS OFF WORK</u> (OR UNABLE TO DO HOUSEWORK) DURING THE LAST:

3 weeks → days_____	6 months → days_____		
6 weeks → days_____	12 months → days_____	(IF <u>NO DAYS OFF</u>, ☐ **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?

<u>Doctors</u> (Give names, dates):

<u>Chiropractors</u> (Give names, dates):

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

By Whom? _____ Did they help? _____

28. <u>ANY PHYSICAL THERAPY TREATMENTS</u>? ☐ 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 unitl this occurance
- ☐ 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 unitl this occurance
- ☐ Neck pain had not 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 occurance
- ☐ 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

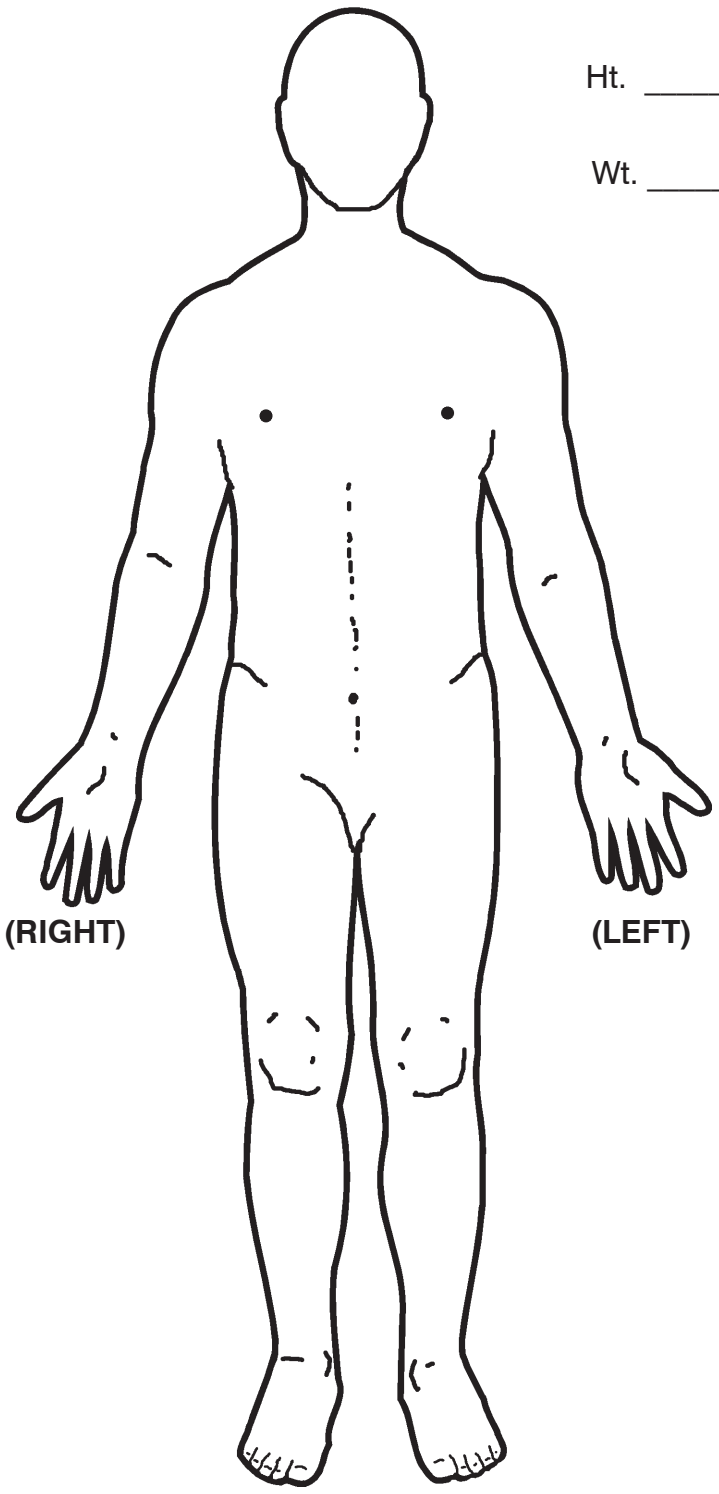
Spasms and/or cramps

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

FRONT

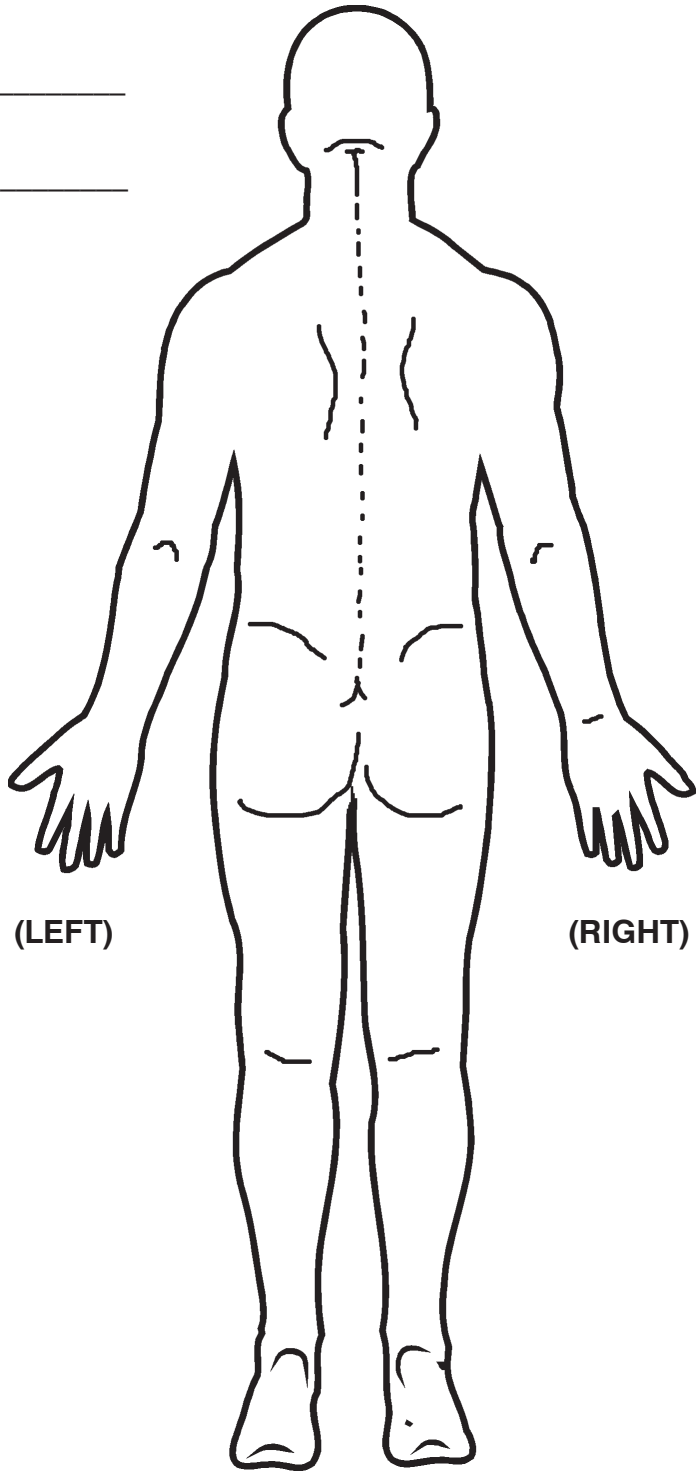
Ht. _____

Wt. _____



(RIGHT) **(LEFT)**

BACK



(LEFT) **(RIGHT)**

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**?

☐ Exercise (during)
☐ Exercise (after)
☐ Prolonged sitting
☐ Prolonged standing
☐ Arching backwards
☐ Bending over forwards
☐ Bending to the right side
☐ Bending to the left side
☐ Twisting to the right
☐ Twisting to the left
☐ Walking (at first)
☐ Walking (later on)
☐ Getting in or out of cars and chairs
☐ Driving a car
☐ Coughing
☐ Sneezing
☐ Straining at stool
☐ Lifting
☐ Climbing stairs
☐ Putting on socks, stockings and/or shoes
☐ Weather changes (rain, etc.)
☐ Heat ☐ Cold
☐ Resting ☐ Nothing
☐ 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**?

☐ Rest
☐ Lying down
☐ Heat
☐ Cold
☐ Exercise (during)
☐ Exercise (after)
☐ Walking
☐ Changing Positions
☐ Manipulations
☐ Lying flat on back
☐ Neck Collar
☐ Neck traction
☐ Injection for pain
☐ Pain pills
☐ Muscle relaxers
☐ Aspirin or anti-inflammatory pills
☐ Other medications
☐ Alcohol
☐ Nothing
☐ 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?

_____ Lie down in one position
_____ Sit in one position
_____ Stand in one position
_____ Walk
_____ Shop
_____ 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?

_____

_____

_____

_____

_____

DO NOT FILL OUT THIS PAGE EXAM DATE: _____

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:

Babinksi's:

Clonus

Atrophy – Shoulder(s)

Arm(s)

Hand(s)

Pulses –

Adson's test –

SIGNED _____