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Patient Name:_____ Today's Date:_____

CHIEF COMPLAINT-NECK PAIN

	LEAVE THIS SIDE BLANK FOR DOCTOR'S USE
1. Where is the pain? Describe the spot where the pain is.	
2. Does the pain radiate down the arm- to the arm or hand?	
3. Is there is any sensory change, numbness or tingling:	
4. Is there numbness and tingling? Where? Which fingers are involved?	
5. When does the tingling occur?	
6. Is the tingling worse at night in sleep?	
7. Is your neck pain one-sided or bilateral- both sides?	
8. Is one side more painful than the other? If so, which?	
9. Have you had a serious head trauma, automobile accident, or whiplash? Was the headache caused? Or worsened? By the accident?	
10. Have you had any diagnostic testing? If so, when and where? a. MRI scan What results? b. Test of nerves by EMG What Results?	

CHIEF COMPLAINT-NECK PAIN (Continued)

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11. What medications do you take for the pain? Does	

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the medication work? A.) B.) C.) D.)	
12. Does the neck pain affect your sleep or awaken you from sleep?	
13. Have you lost any strength in your arms or hands? Where: Left or Right or Both Arms Only or Arms and Hands	
14. Do you have trouble opening jars or lifting?	
15. Do the muscles jump or quiver under the skin?	
16. Have you taken any therapy? If so, with what results? When? Where? How many sessions?	
17. Does the shoulder joint, itself, hurt? Both or One?	
18. Does the neck pain interfere with your lifestyle or work or exercise?	

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