

NECK OR SHOULDER PAIN

Patient's Name _____ Date _____

Where is the pain located?

- Neck Right Shoulder Left shoulder

In what area of the neck or shoulder is the pain located? _____

What is the quality (description) of the pain?

- Aching Burning Gnawing Numbing Electric Shock Stabbing
 Sensation of Heaviness Other, describe: _____

On a severity scale of 1-10 (1 being little pain at all and 10 being intolerable) my pain is a _____

Measure the severity of the pain regarding how it affects your daily activities:

- Mild – I am aware of it when present but it doesn't interfere with daily activities
 Moderate – when present it interferes only with some daily activities
 Severe – when present it interferes with most, but not all, daily activities
 Very severe – when present I am unable to carry out any daily activities
 Other description of severity _____

Are you experiencing the pain now? Yes No

How long have you had the pain? _____

Setting in which problem first occurred:

- Around the house Recreation School Fall
 Injury on the job
 Date of accident: _____
 Description of accident or injury: _____
 Was it reported to workman's comp? Yes No
 Are you off work due to the accident or injury? Yes No
 Motor vehicle accident
 Circumstances of accident: _____
 Overuse, repetitive motion injury, briefly describe: _____
 Sports injury, briefly describe: _____
 Other, briefly describe: _____
 Unknown

List any factors that aggravate the pain: _____

List any non-medical factors that relieve the pain: _____

Are you experiencing arm pain? Yes No

- Left Arm Right Arm Both Arms

What area of the arm is the pain located?

- Shoulder Upper Arm Forearm Hands Fingers

What is the quality (description) of the pain?

- Aching Burning Cold Sensation Hot Sensation Stabbing Weakness
 Gnawing Numbing Heavy Sensation Electric Shock Tingling Pins/Needles

List any previous tests you have had: _____

Do you drop objects? Yes No

Do you have: Sleep disturbance Bowel dysfunction Bladder dysfunction

List any previous treatments you have had: (home remedies, physical or occupational therapies, acupressure or acupuncture therapies, massage therapy, chiropractic therapy, etc) and their effectiveness:

List any medications you have tried for this problem and their effectiveness:

