

NAPOLI CHIROPRACTIC CENTER

NECK PAIN CASE HISTORY

1. Where is your neck pain? (Right side, mid line, left side, upper or lower)

2. When did the pain begin?

How did the neck pain begin?

3. When does it cause pain?

With head movements? Yes _____ No _____

Constantly? Yes _____ No _____

In the morning? Yes _____ No _____

At the end of the day? Yes _____ No _____

4. Is the pain sharp or a dull ache?

5. Do you have headaches with your neck pain? Yes _____ No _____

How often are the headaches?

Are they on the right side, left side, or in the back of the head?

6. Are you experiencing arm sensations? (pain, numbness, tingling) Yes _____ No _____

Right _____ Left _____

Do you have trouble using the arm? Yes _____ No _____

Do you drop things frequently? Yes _____ No _____

7. Does coughing, sneezing, or having a bowel movement increase your pain?

Yes _____ No _____

Signature _____ Date _____