



Patient Name: _____

Date of Birth: _____

Neck Intake Survey:

1. In general, would you say your health is:

Excellent Very Good Good Fair Poor

2. How much difficulty do you have lifting/carrying items?

Unable to perform A lot Some A little None

3. How much difficulty do you have reaching overhead?

Unable to perform A lot Some A little None

4. How much difficulty do you have gripping?

Unable to perform A lot Some A little None

5. How much difficulty do you have opening doors/cans?

Unable to perform A lot Some A little None

6. How much difficulty do you have working at a computer >30 mins?

Unable to perform A lot Some A little None

7. How much difficulty do you have turning your head while driving?

Unable to perform A lot Some A little None

8. Please indicate your pain range within the last week giving a score for the lowest and highest on the scale below.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever