Medico-Legal Evaluations, P.A.
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Neck Injury Questionnaire

Fill out only the form(s) for the body area(s) that were injured. Type into this form on a computer or phone, save it and email it to **info@mlenj.com** before your appointment, or print it and bring it. Please also bring any X-ray, MRI or CT films or discs.

Full name | **Date of birth** | **Today's date**

Your injury

When did the injury happen?

How did the injury happen?

Before and after this injury

Before this injury, did you have any of these? (check all that apply)

☐ A neck injury ☐ Neck pain or problems ☐ Neck treatment ☐ None of these

If you checked any, when and what happened (for example, another accident)?

Any other accidents or injuries since this injury? ☐ Yes ☐ No If yes, what happened?

Treatment and work

Which treatments have you had for this injury? (check all that apply)

☐ Surgery ☐ Injections ☐ Physical therapy ☐ Chiropractic treatment Other:

Work status: (check one)

☐ Full duty ☐ Light or restricted duty ☐ Not working because of this injury ☐ Retired ☐ Not working, other reason

Your job (or last job):

Pain

Do you have pain right now? ☐ Yes ☐ No

Pain right now

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Pain at its worst in the last week

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Where is the pain?

Check one box on each line that hurts. Leave the line blank if it does not hurt.

Area	Hurts	If it hurts, which side?		
		Left	Right	Both
Head / headaches	☐	—	—	—
Neck	☐	—	—	—
Shoulder	—	◯	◯	◯
Arm	—	◯	◯	◯
Hand	—	◯	◯	◯

What is the pain like? (check all that apply)

☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Stinging

Other:

How often do you have pain? ☐ Sometimes ☐ Most of the time ☐ All the time

Do you have numbness, tingling or other unusual feelings in your arms or hands? ☐ Yes ☐ No

If yes, which side? ☐ Left ☐ Right ☐ Both Describe:

Pain medications you take:

Activities

Which of these activities are harder for you **because of the injury or injuries described on this form?** For each activity, **check only one box**. Leave the row blank if the injury does not affect that activity.

Activity	I can't do it anymore	I can do it, but less than before	I can do it normally, but feel pain
Lifting and carrying			
Lifting	○	○	○
Carrying objects	○	○	○
Picking up children	○	○	○
Head and neck positions			
Using a computer	○	○	○
Reading or looking down at a phone	○	○	○
Driving (turning your head)	○	○	○
Reaching or working overhead	○	○	○
Reaching high shelves	○	○	○
Household tasks			
Doing laundry	○	○	○
Vacuuming or sweeping	○	○	○
Cooking	○	○	○
Exercise and recreation			
Riding a bicycle	○	○	○
Playing sports	○	○	○
Working out or lifting weights	○	○	○
Daily activities			
Getting dressed	○	○	○
Sleeping	○	○	○
Sexual activity	○	○	○

Any other activities that are harder because of this injury: