GP THERAPY, LLC **D.B.A.**
GERMANTOWN PHYSICAL THERAPY
Telephone 301-916-0164 Facsimile 301-540-0722

Patient: _____ Region: Neck

1. Describe your pain (sharp, dull, radiating, etc)_____
2. When and how did it start?_____
3. What makes it better? Worse?_____
4. Have you had other treatment for this condition? If so, what kind?_____
   _____
5. Rate your average pain intensity over the past week on the 0 to 10 scale with 10 being the worst pain imaginable. _____/10
6. Average number of times you wake each night due to **neck** pain. _____
7. Sitting tolerance is _____ minutes.
8. Driving tolerance is _____ minutes.
9. Reading tolerance is _____ minutes.
10. Walking tolerance is _____ minutes.

For questions 11 through 18, circle the number that best describes your level of difficulty with the following activities. 0 indicates no difficulty, whereas 10 indicates the inability to perform the activity at all.

	No Difficulty										**Extreme Difficulty**
11. Working at your PC	0	1	2	3	4	5	6	7	8	9	10
12. Ability to concentrate	0	1	2	3	4	5	6	7	8	9	10
13. Dressing	0	1	2	3	4	5	6	7	8	9	10
14. Washing/brushing your hair	0	1	2	3	4	5	6	7	8	9	10
15. Reaching above shoulder level	0	1	2	3	4	5	6	7	8	9	10
16. Turning your head and neck	0	1	2	3	4	5	6	7	8	9	10
17. House cleaning	0	1	2	3	4	5	6	7	8	9	10
18. Social life	0	1	2	3	4	5	6	7	8	9	10

19. What is your current occupation?_____
20. Does your pain affect your occupation? If so, how?_____
    _____
21. Does your pain affect home life? If so, how?_____
    _____
22. Does your pain affect your recreation/leisure/sports? If so, how? _____
    _____

Patient's Signature: _____ Date: _____/_____/_____