

Bonsall Chiropractic

Visual Analog Scale of Neck & Associated Pain

Name: _____ Date: _____

Please mark on the 1 to 10 scale your involvement with pain to the following locations and situations, from no involvement (0) to maximum involvement (10). mark the scale with a vertical line like this:

1. Do you have any pain in your neck? How severe is it?

No pain 0 | | | | | | | | | | | 10 *Intolerable*

2. Do you have any pain in the night? How severe is it?

No pain 0 | | | | | | | | | | | 10 *Intolerable*

3. Does activity give you pain? Yes _____ No _____ If so, how much activity is required to cause you pain?

A great deal of activity 0 | | | | | | | | | | | 10 *Almost no activity*

4. Do you use pain killers? Yes _____ No _____ If so, how much relief?

Complete relief 0 | | | | | | | | | | | 10 *No relief*

5. Do you have any stiffness in your neck?

No stiffness 0 | | | | | | | | | | | 10 *Intolerable stiffness*

6. Do you have pain in your shoulder and/or arm? (Mark for right and left.)

None at all *Right* 0 | | | | | | | | | | | 10 *Intolerable*
Left 0 | | | | | | | | | | | 10

7. Does your pain interfere with the use of your arm/or hand? (Mark for right and left.)

None at all *Right* 0 | | | | | | | | | | | 10 *Not able to*
Left 0 | | | | | | | | | | | 10 *use it at all*

8. Do you have numbness or tingling in your arm and/or hand? (Mark for right and left.)

None at all *Right* 0 | | | | | | | | | | | 10 *Intolerable*
Left 0 | | | | | | | | | | | 10

9. Do you have headaches? If so, how severe are they?

None at all 0 | | | | | | | | | | | 10 *Intolerable*

10. How frequent are your headaches if you have them?

Infrequent 0 | | | | | | | | | | | 10 *All the time*

11. Is your pain worse when riding in a car?

Complete freedom to ride in a car 0 | | | | | | | | | | | 10 *Such discomfort that I cannot ride in a car at all*

12. Do you have pain when lying down in bed?

Complete comfort 0 | | | | | | | | | | | 10 *No comfort at all*

13. What is your overall handicap in your complete life-style because of neck, head, shoulder, and/or arm pain?

Completely free to perform any task 0 | | | | | | | | | | | 10 *Totally handicapped*

14. To what extent does your pain interfere with your work?

No interference at all 0 | | | | | | | | | | | 10 *Totally incapable of work*

15. To what extent does your work have to be modified so that you are able to do your job?

No adjustment to work 0 | | | | | | | | | | | 10 *So much adjustment that I have had to change jobs*