IceFire Physiotherapy

	Neck Pain Screening Questionnaire© (adapted from the work of Prof D Reid & Prof W Hing)		
First Name		Date of Birth	
Last Name		Date questionnaire completed	
Email		Phone	
	Please circle the correct answers, or enter in the correct number, such as 3 per week. We understand that you may not wish to answer all the questions. **We can still assess and treat you if you don't wish to answer all the questions.**		
	Do you suffer from headaches, including migraines?	Yes	No
	If yes, answer questions 1a to 1e below:		
	What is the frequency of your migraines?	…. per week	… per month
	What is the frequency of your headaches?	…. per week	… per month
	On a scale from 0 to 10 (0 = no pain, 10 = worst pain imaginable), how much **headache/migraine pain** did you have in general yesterday?		
	0 1 2 3 4 5 6 7 8 9 10		
	On a scale from 0 to 10 (0 = no pain, 10 = worst pain imaginable), how much **headache/migraine pain** did you have in general today?		
	0 1 2 3 4 5 6 7 8 9 10		
	Do you suffer from headaches/migraines **only when** you have neck pain?	Yes	No
	On a scale from 0 to 10 (0 = no pain, 10 = worst pain imaginable), how much **neck pain** did you have in general yesterday?		
	0 1 2 3 4 5 6 7 8 9 10		
	On a scale from 0 to 10 (0 = no pain, 10 = worst pain imaginable), how much **neck pain** did you have in general today?		
	0 1 2 3 4 5 6 7 8 9 10		
	Does your neck pain usually increase from the morning to the evening?		
	Have you had a recent or previous trauma to the neck or head? For example: neck cracking/manipulation; heavy lifts that hurt your neck	Yes	No
	Do you experience **D**iplopia (i.e. double vision)	Yes	No
	Do you experience **D**ysarthria (i.e. difficulty speaking)	Yes	No
	Do you experience **D**ysphagia (i.e. difficulty swallowing)	Yes	No
	Do you experience **D**izziness	Yes	No
	Do you experience **D**rop attacks (ie. when you turn your head you fall to ground)	Yes	No

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	Do you experience **A**taxia (i.e. difficulty coordinating your muscles such as walking, jumping, lifting with both hands)	Yes	No
	Do you experience **N**ausea	Yes	No
	If yes, what is the frequency of your nausea?	…. per week	… per month
	If yes, has it made you want to vomit over the last week?	Yes	No
	Do you experience **N**ystagmus (i.e your eyes move in a repetitive uncontrolled manner)	Yes	No
	Do you experience **N**umbness of the face, lips and/or tongue	Yes	No
	Do you experience Light headedness	Yes	No
	Do you experience Blurred vision	Yes	No
	Do you experience Postural hypotension (i.e feeling light headed when moving from sit to stand or from lying on your bed to sitting)	Yes	No
	Do you experience Tinnitus (ie. ringing in the ears)	Yes	No
	Do you have Rheumatoid arthritis		
	Do you have Thyroid disease (Hypothyroidism, hyperthyroidism, Hashimoto's disease, Grave's disease)	Yes	No
	Do you have Atherosclerosis (hardening of the arteries or blocked arteries)?	Yes	No
	Do you have high blood pressure	Yes	No
	If yes, is it controlled by your present medication?	Yes	No
	Do you have high cholesterol levels	Yes	No
	If yes, are they controlled by your present medication?	Yes	No
	Do you have Type 1 diabetes	Yes	No
	Do you have Type 2 diabetes	Yes	No
	Do you have Hyperhomocysteinaemia (high blood levels of homocysteine) or have low blood levels of either folate, or Vitamin B9, or Vitamin B12	Yes	No
	Do you take anticoagulant (blood thinning) medication such as aspirin?	Yes	No
	Do you take oral contraceptives? The use of combined oral contraceptives (COCs) is associated with a much greater risk clotting events that can cause stroke. If you also smoke you have a 10 fold greater likelihood of heart attack and a three fold greater risk of a stroke. If appropriate, please circle these words: **I don't wish to answer.**	Yes	No
	Are you between 30 and 45 years old?	Yes	No
	Are you a smoker? If you are a smoker, you may find it interesting to read Jonathan Clerke's article titled: *Does smoking tobacco cigarettes slow down the healing of soft tissue wounds?* which can be found on the IceFire Physiotherapy website.	Yes	No
	Signature	Date of signature	