

NECK AND SHOULDER SCREENING QUESTIONNAIRE

NAME: _____

DATE: _____

Medical Record #: _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you recently experienced a blow to the head or a whiplash injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have rheumatoid arthritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking steroids or have you been on prolonged steroid therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you noticed any recent weakness, tingling, or numbness in you arms or legs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you noticed a <i>recent</i> onset of difficulty with retaining your urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you now smoke or have you been a smoker in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you administer medicine or drugs to yourself for which you need to inject using a needle? | <input type="checkbox"/> | <input type="checkbox"/> |