

NECK FABQPA

Name: _____

Date: ___/___/___
 mm dd yy

Here are some of the things other patients have told us about their pain. For each statement please circle the number from 0 to 6 to indicate how much physical activities such as driving, lifting, or turning affect or would affect your neck pain.

	Completely Disagree		Unsure		Completely Agree		
1. Physical activity makes my pain worse.	0	1	2	3	4	5	6
2. Physical activity might harm my neck.	0	1	2	3	4	5	6
3. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
4. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6