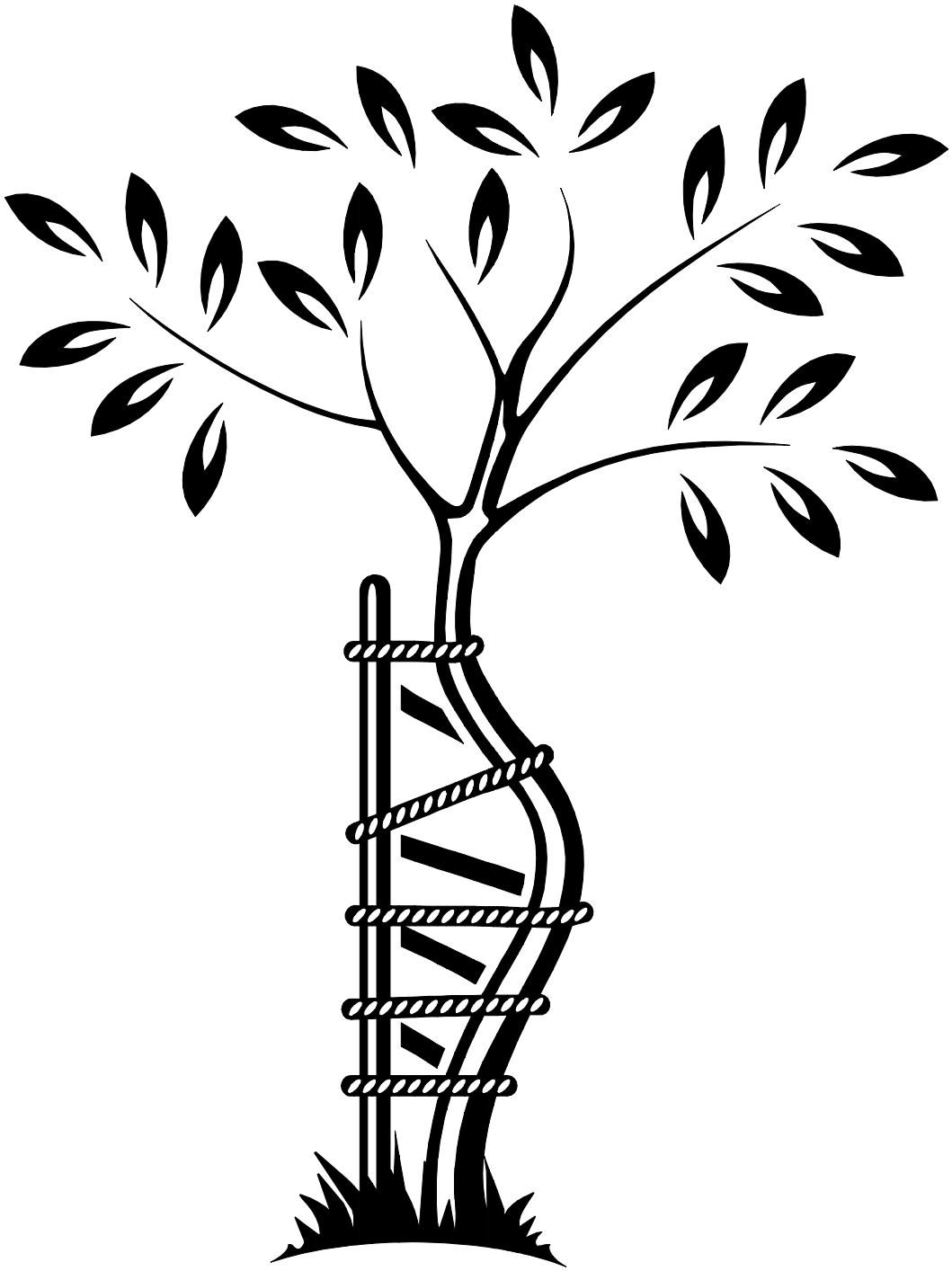
Cervical Spine

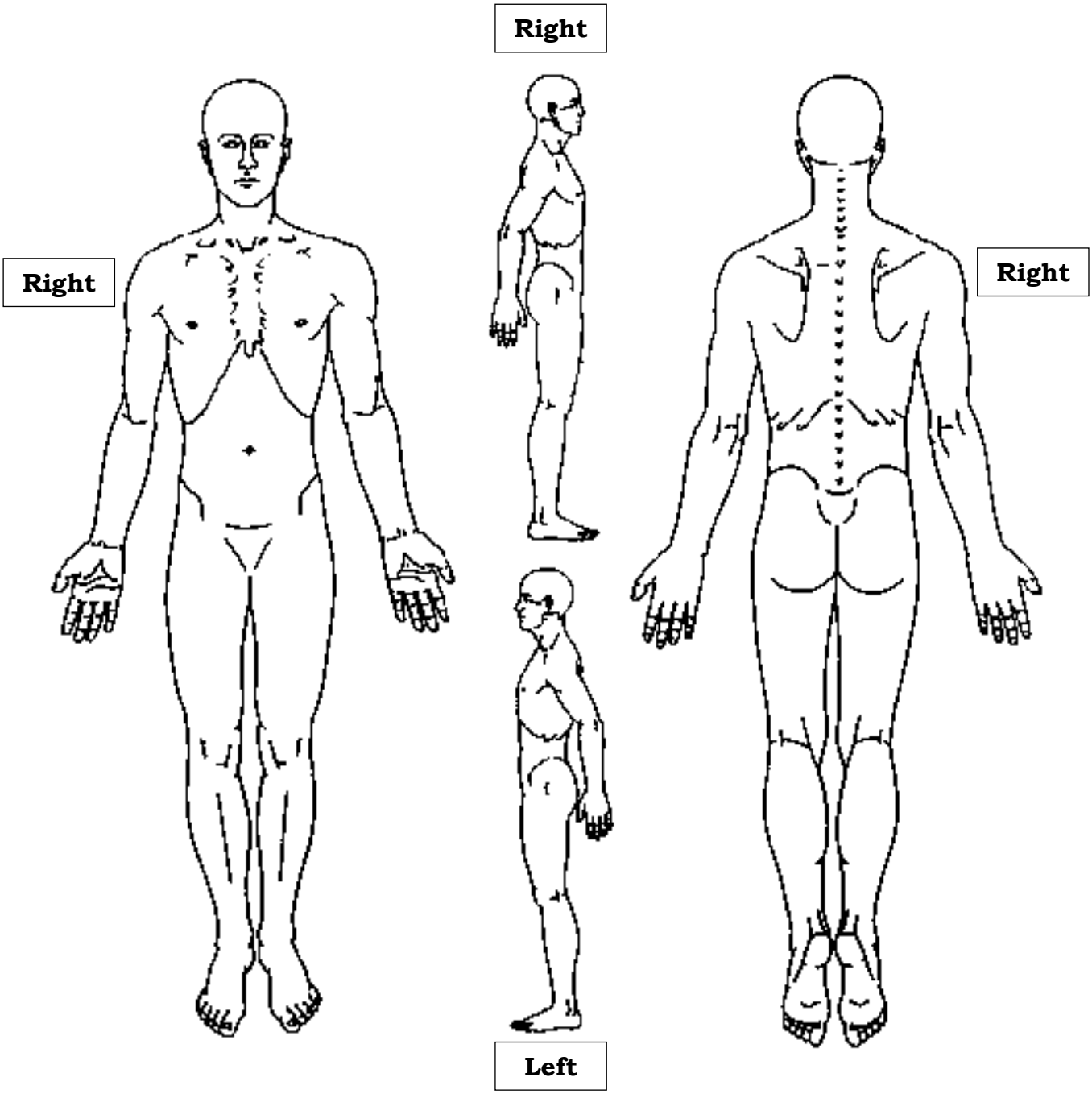
New Patient Form



Please mark the painful areas on the pictures below

Use the following marks: ●●●●● stabbing pain **000** burning pain +++ aching pain

□□□ pins and needles = = = numbness



Date _____

Name _____

Referred by _____

Age _____ Date of Birth _____ Gender: _____

Major complaint

Enter the percentage of pain (from 1% to 100%) for each area **(the sum should be 100%)**

Neck: _____ % Arms (including hands): _____ %

Mark the degree of pain with an X on the lines below

(Indicate the **least** and the **worst** pain, as well as the **average** amount of pain)

Neck

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Arms

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Hands

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Head

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

When did symptoms start? _____

How did symptoms start? _____

_____

Do you feel any numbness? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

Do you feel any tingling? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

Do you have any weakness? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

What tests have been done on your neck or back in the last year:

❑ X-rays ❑ MRI ❑ CT Scan ❑ Myelogram ❑ EMG ❑ Discogram

❑ CT Myelogram ❑ Neurogram ❑ Bone density study

I have tried:

❑ (1) Physical therapy	❑ Not helpful	❑ Helpful
❑ (2) Stretching	❑ Not helpful	❑ Helpful
❑ (3) Exercises	❑ Not helpful	❑ Helpful
❑ (4) Acupuncture	❑ Not helpful	❑ Helpful
❑ (5) Chiropractors	❑ Not helpful	❑ Helpful
❑ (6) TENS Unit	❑ Not helpful	❑ Helpful
❑ (7) Traction	❑ Not helpful	❑ Helpful
❑ (8) Medications	❑ Not helpful	❑ Helpful
❑ (9) Epidural injection	❑ Not helpful	❑ Helpful – Duration of effect _____
❑ (10) Facet injection	❑ Not helpful	❑ Helpful – Duration of effect _____
❑ (11) SI (sacroiliac) injection	❑ Not helpful	❑ Helpful – Duration of effect _____
❑ (12) Radiofrequency ablation	❑ Not helpful	❑ Helpful – Duration of effect _____

How do the following activities usually affect your pain?

Sitting	❑ Relieves pain	❑ Worsens pain	❑ No effect
Standing	❑ Relieves pain	❑ Worsens pain	❑ No effect
Walking	❑ Relieves pain	❑ Worsens pain	❑ No effect
Lying on my side	❑ Relieves pain	❑ Worsens pain	❑ No effect
Lying on my back	❑ Relieves pain	❑ Worsens pain	❑ No effect
Lying on my stomach	❑ Relieves pain	❑ Worsens pain	❑ No effect
Leaning forward (as with brushing teeth)	❑ Relieves pain	❑ Worsens pain	❑ No effect
Bending forward	❑ Relieves pain	❑ Worsens pain	❑ No effect
Bending backward	❑ Relieves pain	❑ Worsens pain	❑ No effect
Driving	❑ Relieves pain	❑ Worsens pain	❑ No effect
Coughing or sneezing	❑ Relieves pain	❑ Worsens pain	❑ No effect

How long can you do the following without pain?

Sit	____ minutes	____ hours	❑ no restriction
Stand	____ minutes	____ hours	❑ no restriction
Walk	____ minutes	____ hours	❑ no restriction

Neck Disability Questionnaire

Please circle **one** best answer per section.

SECTION 1 - Pain Intensity

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

1. I can look after myself normally without causing extra pain.
2. I can look after myself normally, but it is very painful.
3. It is painful to look after myself and I am slow and careful.
4. I need some help, but manage most of my personal care.
5. I need help every day in most aspects of self-care.
6. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it gives extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

SECTION 4 - Reading

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate neck pain
4. I cannot read as much as I want due to moderate neck pain
5. I cannot read as much as I want due to severe neck pain
6. I cannot read at all.

SECTION 5 - Headaches

1. I have no headaches at all.
2. I have slight headaches which come infrequently.
3. I have moderate headaches which come infrequently.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come frequently.
6. I have headaches almost all the time.

SECTION 6 - Concentration

1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to.
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

SECTION 7 - Work

1. I can do as much work as I want to.
2. I can only do my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

SECTION 8 - Driving

1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all due to severe neck pain
6. I cannot drive my car at all.

SECTION 9 - Sleeping

1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours).

SECTION 10 - Recreation

1. I am able to engage in all of my recreational activities with no neck pain at all.
2. I am able to engage in all of my recreational activities with some pain in my neck.
3. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
4. I am able to engage in a few of my recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Review of Systems

In the past month I have had (mark anything that applies):

General

1. ❑ Fever
2. ❑ Chills
3. ❑ Unexplained weight loss
4. ❑ Night sweats
5. ❑ Fatigue
6. ❑ Loss of appetite

Neurological

7. ❑ Numbness
8. ❑ Dizziness
9. ❑ Tingling
10. ❑ Tremors
11. ❑ Dyscoordination
12. ❑ Migraines
13. ❑ Headaches
14. ❑ Memory problems

Musculoskeletal

15. ❑ Joint pain
16. ❑ Joint stiffness
17. ❑ Joint swelling
18. ❑ Joint redness

Pulmonary

19. ❑ Cough
20. ❑ Shortness of breath
21. ❑ Wheezing

Cardiac

22. ❑ Chest pain at rest
23. ❑ Chest pain with activity
24. ❑ Irregular heartbeat

Gastrointestinal

25. ❑ Abdominal pain
26. ❑ Diarrhea
27. ❑ Constipation
28. ❑ Incontinence
29. ❑ Blood in stool
30. ❑ Heartburn
31. ❑ Pain with bowel movement

Urological

32. ❑ Pain with urination
33. ❑ Blood in the urine
34. ❑ Cloudy urine
35. ❑ Incontinence
36. ❑ Increased urgency
37. ❑ Increased frequency

Skin

38. ❑ Rash
39. ❑ Itching
40. ❑ Discoloration

Ear/ Nose/ Throat

41. ❑ Difficulty swallowing
42. ❑ Hoarseness
43. ❑ Voice changes

Extremities

44. ❑ Leg pain with walking
45. ❑ Cold hands
46. ❑ Cold feet

Psychological

47. ❑ Frequent crying
48. ❑ Insomnia
49. ❑ Depression
50. ❑ Anxiety
51. ❑ Hearing voices
52. ❑ Hallucinations

Other:

_____

_____

_____

Are you under a doctor's care for any medical condition? ❑ Yes ❑ No

Please list all the other physicians you have consulted with over the past year:

_____

_____

_____

_____

Social Summary

Currently I am: ❑ (1) Working full-time ❑ (2) Working part-time ❑ (3) Student
❑ (4) Unemployed ❑ (5) Homemaker ❑ (6) Retired
❑ (7) On disability

If not currently working, when did you last work? _____

What is your job title? _____

What exercise or athletic activities do you participate in? _____

_____

Currently I am: ❑ (1) Married ❑ (2) Partnered ❑ (3) Divorced ❑ (4) Single ❑ (5) Widowed

How many children do you have? _____

What is your height? _____

What is your weight? _____ I have lost _____ or gained _____ in the last six months.

Will there be a lawsuit or litigation regarding your injury? ❑ Yes ❑ No

Is this injury work related? ❑ Yes ❑ No

If this is a work injury, please answer the following questions:

Is there a workers' compensation claim? ❑ Yes ❑ No

If yes, what was the date of injury? _____

Please describe this injury: _____

_____

How much time do you spend doing the following on the job per day?

Driving	_____ minutes or _____ hours
Sitting	_____ minutes or _____ hours
Walking	_____ minutes or _____ hours
Standing	_____ minutes or _____ hours
Bending	_____ minutes or _____ hours
Lifting	_____ minutes or _____ hours