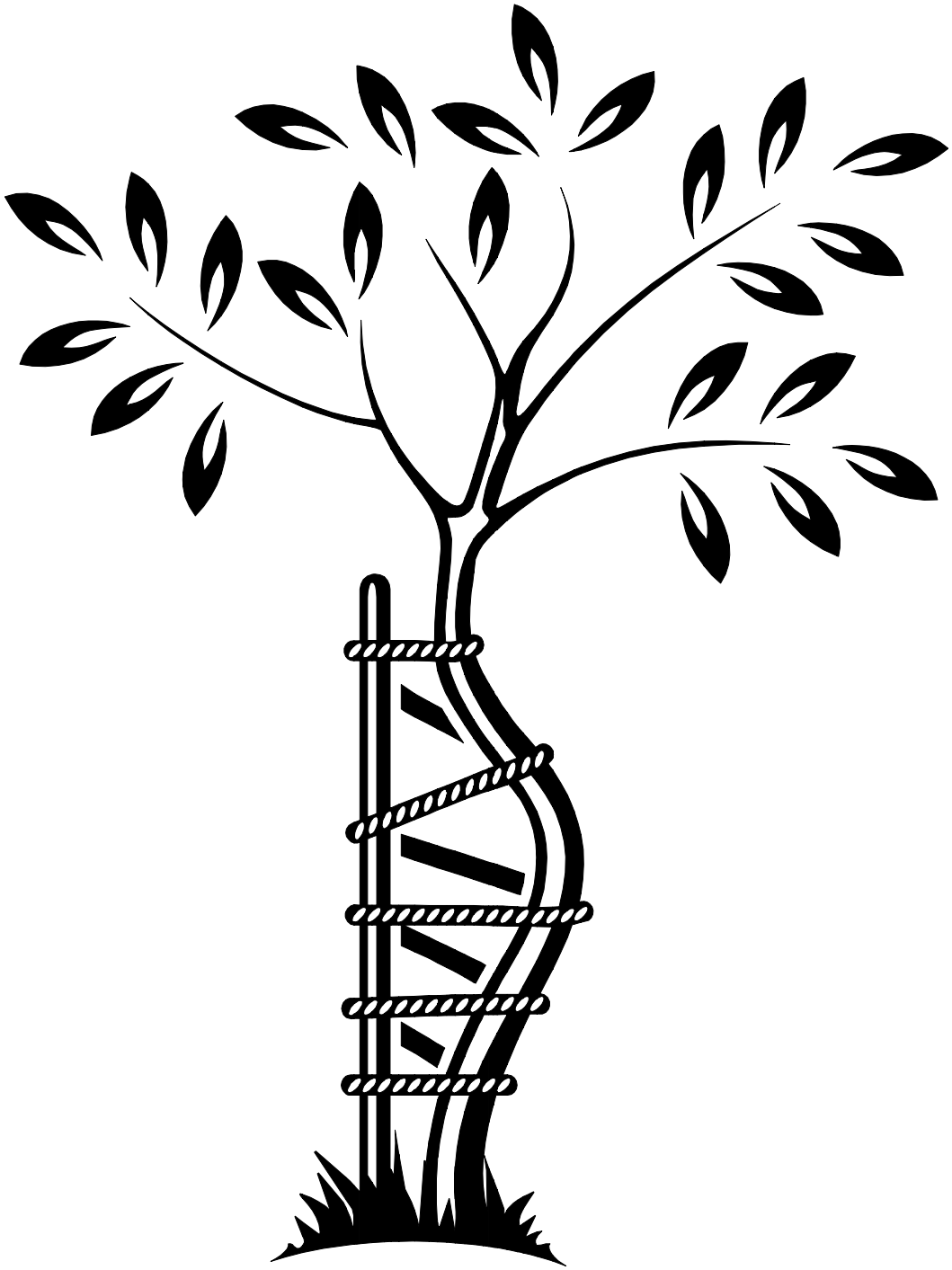
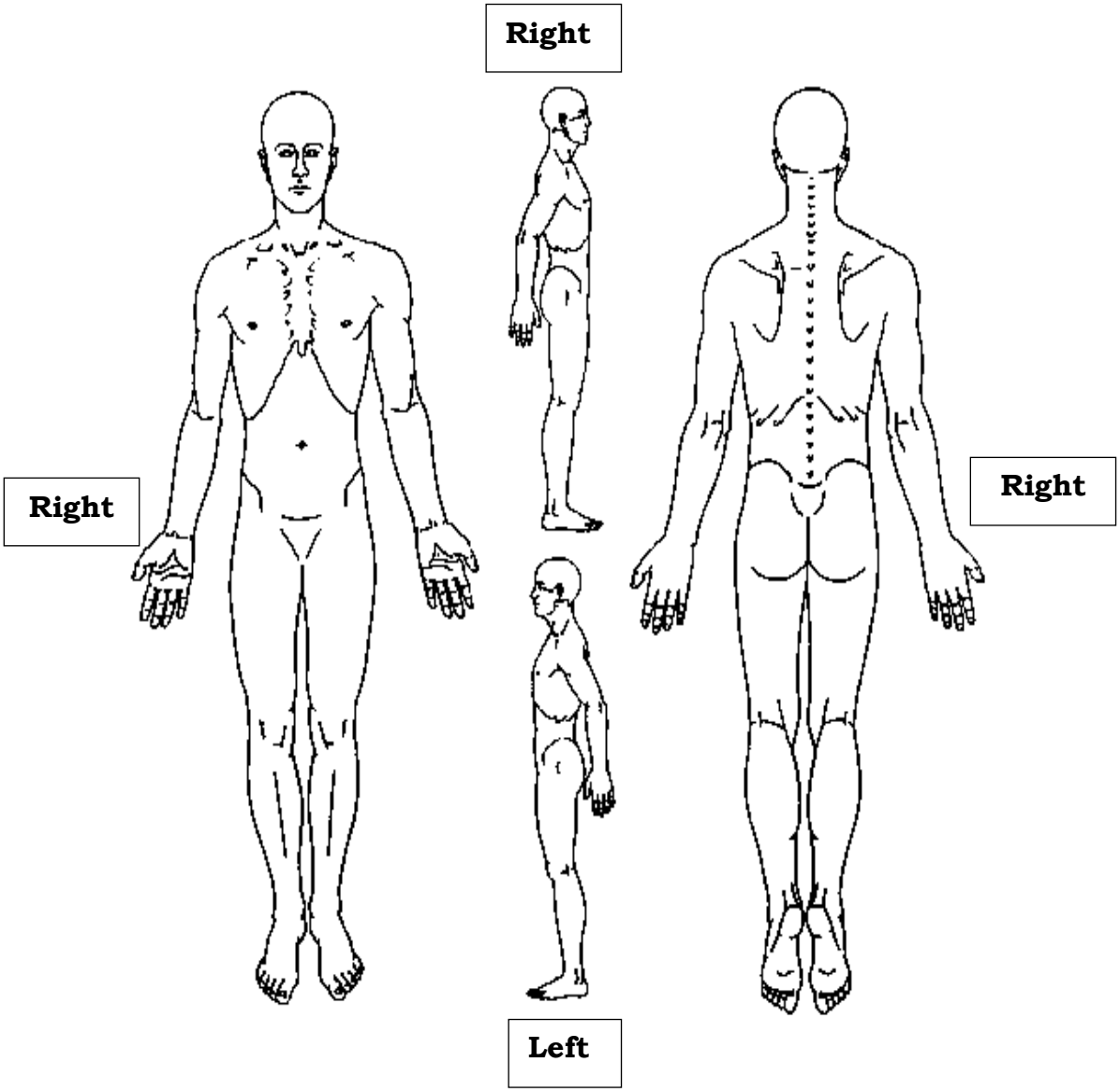
Cervical Spine

New Patient Form



Please mark the painful areas on the pictures below



Use the following:

•••• stabbing pain OOO burning pain +++ aching pain

□□□ pins and needles === numbness

New Patient Questionnaire

Date _____

Name _____

Referred by _____

Age _____ Date of Birth _____

Gender: _____

Major complaint

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

Pain in:

Neck: _____ % Head: _____ %

Left Arm: _____% Right Arm: _____%

Left Hand: _____% Right Hand: _____%

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

I have tried:

1. ❑ Physiotherapy Helpful? ❑ Yes ❑ No
2. ❑ Stretching Helpful? ❑ Yes ❑ No
3. ❑ Exercises Helpful? ❑ Yes ❑ No
4. ❑ Acupuncture Helpful? ❑ Yes ❑ No
5. ❑ Chiropractors Helpful? ❑ Yes ❑ No
6. ❑ TENS Unit Helpful? ❑ Yes ❑ No
7. ❑ Epidural/facet injection Helpful? ❑ Yes ❑ No
8. ❑ Traction Helpful? ❑ Yes ❑ No
9. ❑ Medications Helpful? ❑ Yes ❑ No

My symptoms are relieved by:

1. ❑ Sitting
2. ❑ Standing
3. ❑ Walking
4. ❑ Lying on my side
5. ❑ Lying on my back
6. ❑ Lying on my stomach
7. ❑ Bending forward
8. ❑ Bending backward

My symptoms are worsened by:

1. ❑ Sitting
2. ❑ Standing
3. ❑ Walking
4. ❑ Lying on my side
5. ❑ Lying on my back
6. ❑ Lying on my stomach
7. ❑ Bending forward
8. ❑ Bending backward

How long can you do the following without pain?

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

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

❑ (1) Regular X-rays ❑ (2) MRI ❑ (3) CT Scan ❑ (4) Myelogram

❑ (5) EMG ❑ (6) Discogram ❑ (7) CT Myelogram ❑ (8) Neurogram

❑ (9) Bone density study

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(2-3hrs sleepless)
5. My sleep is greatly disturbed (3-5 hrs 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. ❑ Bowel incontinence
29. ❑ Blood in stool
30. ❑ Heartburn
31. ❑ Pain with bowel movement

Urological
32. ❑ Pain/burning with urination
33. ❑ Bloody/cloudy urine
34. ❑ Urinary incontinence
35. ❑ Increased urinary urgency
36. ❑ Increased urinary frequency

Skin
37. ❑ Rash
38. ❑ Itching
39. ❑ Discoloration

Ear/ Nose/ Throat
40. ❑ Difficulty swallowing
41. ❑ Hoarseness
42. ❑ Voice changes

Extremities
43. ❑ Leg pain with walking
44. ❑ Cold hands
45. ❑ Cold feet

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

Social Summary

Are you on disability? ❑ Yes ❑ No If yes, since when?_____

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

Is this injury work related? ❑ Yes ❑ No

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

If yes, please list the date of injury: _____

Please describe the mechanism of this injury: _____

Currently I am:

1. ❑ Working full-time
2. ❑ Working part-time
3. ❑ Student
4. ❑ Unemployed
5. ❑ Homemaker
6. ❑ Retired

What kind of work do you do?

_____

If not currently working, when did you last work?

_____

What sports/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? _____

How much weight have you lost _____ or gained _____ in the last six months?

Medical History

What medical problems have you had?

❑ (1) High blood pressure ❑ (2) Heart Disease ❑ (3) Lung disease ❑ (4) Diabetes

❑ (5) Cancer ❑ (6) Blood problems ❑ (7) Stomach/intestinal problems ❑ (8) Depression

❑ (9) Anxiety ❑ (10) Kidney disease

❑ Other: _____

_____

What surgeries have you had? ❑ None

_____

_____

_____

_____

_____

I have a family history of:

❑ (1) Neck problems ❑ (2) Back problems ❑ (3) Arthritis ❑ (4) Blood clots

❑ (5) Heart disease ❑ (6) Diabetes ❑ (7) Cancer

❑ Other: _____

_____

Do you smoke? ❑ Yes ❑ No ❑ I quit _____ days / months / years ago

How many packs per day? _____

Do you drink alcohol? ❑ Yes ❑ No

How many drinks per day? _____

Do you have any medication allergies? ❑ Yes ❑ No

Please list them: _____

_____

_____

Please list all medications on the next page.

Please list all your medications (including dose and frequency):