



Cervical Spine

New Patient Forms



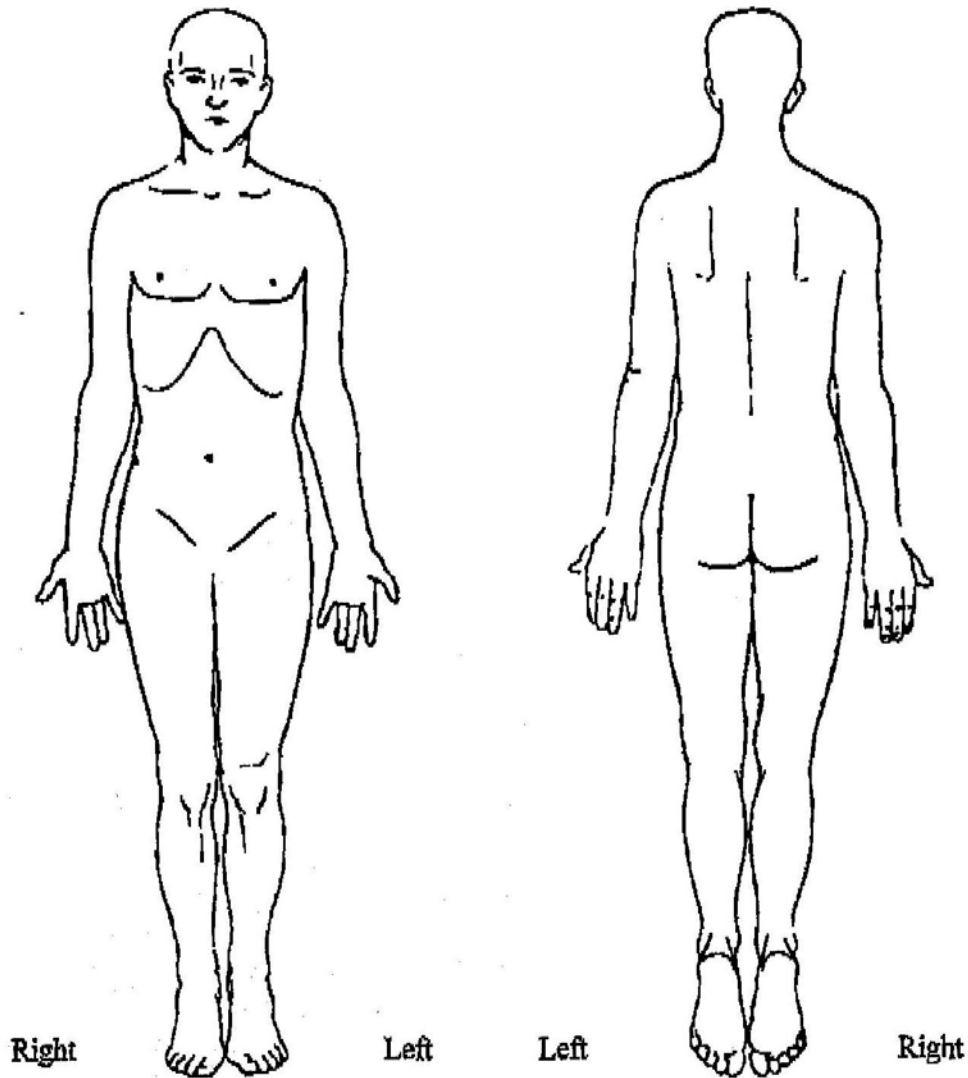
Your cooperation in answering all these questions is greatly appreciated.
It will help in your evaluation

Name: _____ Date: _____

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing. Using the diagrams below, use the symbols listed below to indicate what type of pain you are having and where it is located:

---	Numbness
□□□	Pins and needles
○○○	Burning pain
△△△	Stabbing pain
×××	Aching pain



Name: _____ Date: _____

Date of Birth: _____ Gender: M F

What is your Height: _____ What is your Weight: _____

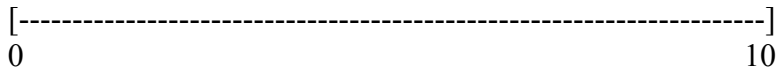
Who referred you here: _____

MAJOR Complaint: (if both neck and arm please give a PERCENTAGE in each)

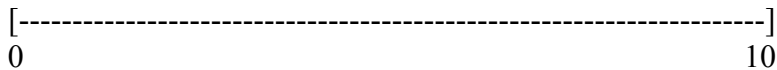
Pain in: Neck _____ Arm _____ Left _____ Right _____

Please indicate the severity of the pain as it is *most* of the time by marking the line with a SINGLE vertical line “|” (0=no pain, 10=worst pain)

Neck



Arm



Duration of current symptoms: _____ Weeks _____ Months _____ Years

Date of initial onset (if known): _____

Is there numbness and/or tingling associated with the pain: Yes No

Is there weakness in the affected arm or hand: Yes No

Have you noticed bowel or bladder problems (e.g. incontinence): Yes No

What have you tried for your symptoms thus far:

- Physical Therapy Traction Exercise
- Acupuncture Chiropractic TENS unit
- Injections Medications Other: _____

Indicate which activities WORSEN your symptoms:

- Sitting Standing Walking
- Lying down Bending forward Bending backward

Indicate which activities IMPROVE your symptoms:

- Sitting Standing Walking
- Lying down Bending forward Bending backward

Name: _____ Date: _____

Is your pain worse:

- In the morning
- Mid-day
- In the evening
- Other: _____

Is your pain better:

- In the morning
- Mid-day
- In the evening
- Other: _____

Which studies of your back or neck, if any, have you had in the last 2 years:

- Regular X-rays
- Bending X-rays
- MRI
- CT Scan
- Myelogram
- EMG
- Discogram
- CT Myelogram

Indicate any Medical History you have:

- High blood pressure
- Heart
- Lung
- Diabetes
- Thyroid
- Kidneys
- Liver
- Stomach
- Other (Please list): _____

Have you ever had neck or back surgery before: Yes No

Please list ALL prior surgeries (Spine AND Non-Spine) with dates (Month/Year):

List (or include a list) of all current Medications:

Are you Allergic to any medications: Yes No

If yes, please list Medication(s) and Reaction(s): _____

Name: _____ Date: _____

Do you smoke or use Tobacco products: Yes No

If yes, for how long: _____

Packs smoked per day: <1/2 1/2 1 2 3 4

Do you drink Alcohol: Yes No

If yes, drinks per day: <1 1 2 3 4 5 >5

Do you use any other Drugs: Yes No If yes, which drugs: _____

Are you on Disability: Yes No If yes, Date started: _____

Is there a lawsuit associate with this injury: Yes No

Is this a workman’s compensation claim: Yes No

If yes, When was the date of injury: _____

BRIEFLY describe the mechanism of injury: _____

Are you currently: Employed Unemployed Student Retired

If employed, what is your occupation: _____

Are you presently working: Yes No

If no, what is the last date worked: _____

Are you: Married/Partnered Single Divorced/Separated Widowed

Number of Children, if any: _____

List any family member, with history of heart, lung, liver or kidney disease; arthritis, gout, glaucoma, or cancer; neck or back problems:

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Name: _____ Date: _____

EXTENDED REVIEW OF SYSTEMS: Do you presently have any problems or symptoms in the following areas? If “Yes”, please explain briefly:

	Yes	No	Explanation:	Provider Comments:
1. General				
Good health	<input type="checkbox"/>	<input type="checkbox"/>		
Unexplained hair loss (alopecia)	<input type="checkbox"/>	<input type="checkbox"/>		
Recent unintentional weight change	<input type="checkbox"/>	<input type="checkbox"/>		
Fever, chills, sweats	<input type="checkbox"/>	<input type="checkbox"/>		
2. Eyes				
Wear glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>		
Vision problems (blurred, double, or loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>		
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ears/Nose/Mouth/Throat				
Change in hearing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>		
Recent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		
Sore throat or pain when swallowing	<input type="checkbox"/>	<input type="checkbox"/>		
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>		
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>		
Voice changes	<input type="checkbox"/>	<input type="checkbox"/>		
4. Cardiovascular				
Heart trouble or heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
Chest pain/angina (sharp, crushing, or heaviness)	<input type="checkbox"/>	<input type="checkbox"/>		
Heart racing/palpitations/arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>		
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>		
Swelling of legs (edema)	<input type="checkbox"/>	<input type="checkbox"/>		
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>		
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>		
5. Respiratory				
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		
Cough	<input type="checkbox"/>	<input type="checkbox"/>		
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>		
Recent pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		
6. Gastrointestinal				
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>		
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>		
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>		
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
7. Endocrine				
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>		
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		
8. Hematologic/Lymphatic				
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
Swollen glands/lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>		
9. Skin and breasts				
Rashes or sores	<input type="checkbox"/>	<input type="checkbox"/>		
Birth marks	<input type="checkbox"/>	<input type="checkbox"/>		

Name: _____ Date: _____

Changing moles	<input type="checkbox"/>	<input type="checkbox"/>		
Skin cancer or melanoma	<input type="checkbox"/>	<input type="checkbox"/>		
Non-healing wounds	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in skin	<input type="checkbox"/>	<input type="checkbox"/>		
Breast pain or lump	<input type="checkbox"/>	<input type="checkbox"/>		
10. Allergic/Immunologic				
Allergic reaction to drugs	<input type="checkbox"/>	<input type="checkbox"/>		
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Hives/skin rashes	<input type="checkbox"/>	<input type="checkbox"/>		
Allergic reaction to foods	<input type="checkbox"/>	<input type="checkbox"/>		
Low resistance to infection	<input type="checkbox"/>	<input type="checkbox"/>		
Recent cold or flu	<input type="checkbox"/>	<input type="checkbox"/>		
Tetanus booster within last 10 years	<input type="checkbox"/>	<input type="checkbox"/>		
Other immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>		
11. Genitourinary				
Painful or burning urination	<input type="checkbox"/>	<input type="checkbox"/>		
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent urination (day and/or night)	<input type="checkbox"/>	<input type="checkbox"/>		
Change in force of stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder infection/other infections	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in sexual function or interest	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>		
<i>Women:</i>				
Irregular periods (menstruation)	<input type="checkbox"/>	<input type="checkbox"/>		
Pain, problems, or changes with periods (menstruation)	<input type="checkbox"/>	<input type="checkbox"/>		
Uterine tumors	<input type="checkbox"/>	<input type="checkbox"/>		
<i>Men:</i>				
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>		
Scrotal Masses	<input type="checkbox"/>	<input type="checkbox"/>		
12. Musculoskeletal				
Limited motion of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Joint stiffness or pain	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>		
Back pain	<input type="checkbox"/>	<input type="checkbox"/>		
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>		
13. Neurological				
Numbness or tingling in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Problems with memory, concentration or speech	<input type="checkbox"/>	<input type="checkbox"/>		
14. Psychiatric				
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>		
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in sleep	<input type="checkbox"/>	<input type="checkbox"/>		
Seeing or hearing things (hallucinations)	<input type="checkbox"/>	<input type="checkbox"/>		
Thoughts of hurting or killing yourself or others	<input type="checkbox"/>	<input type="checkbox"/>		
15. Other (Please write in):				

Name: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire has been designed to give us information as to how your neck or arm pain is affecting your ability to manage in everyday life. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p>SECTION 6 - Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p>SECTION 2 - Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p>	<p>SECTION 7 - Work</p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>SECTION 8 - Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car at all.</p>
<p>SECTION 4 - Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p>SECTION 9 - Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours).</p>
<p>SECTION 5 - Headaches</p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p>SECTION 10 - Recreation</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I cannot do any recreational activities at all.</p>

Name: _____ Date: _____

MSPQ

Please describe how you have felt during the PAST WEEK by making an X in the appropriate box. Please answer ALL questions. Do not think too long before answering.

	Not at all.	Slightly. A little.	A great deal.	Extremely. Could not have been worse.
Heart rate increase...				
Feeling hot all over				
Sweating all over				
Sweating in a particular part of body...				
Pulse in neck...				
Pounding in head...				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal...				
Nausea				
Butterflies in stomach...				
Pain or ache in stomach				
Stomach churning				
Desire to pass water...				
Mouth becoming dry				
Difficulty swallowing...				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles...				

Name: _____ Date: _____

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Please indicate by making an X in the appropriate box) the answer that best describes how you have been feeling recently. Please answer ALL questions. Do not think too long before answering.

	Rarely or none of the time	Some of the time (1-2 days per week)	Good part of the time (3-4 days per week)	Most of the time (5-7 days per week)
I feel downhearted and sad				
Morning is when I feel the best...				
I have crying spells, or feel like it				
I have trouble sleeping at night				
I feel that nobody cares				
I eat as much as I used to...				
I still enjoy sex...				
I notice that I am losing weight				
I have troubles with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be...				
I tend to wake up too early				
I find it easy to do the things I used to...				
I am restless and can't keep still				
I feel hopeful about the future...				
I am more irritable than usual				
I find it easy to make decisions...				
I feel quite guilty				
I feel that I am useful and needed...				
My life is pretty full...				
I feel that others would be better off if I were dead				
I still enjoy the things I used to do...				