Cervical Spine New Patient

Date: _____

PATIENT INFORMATION

Name: _____ Dob: _____ Age: _____

Height: _____ Weight: _____ Bmi: _____

Referring Provider: _____ Primary Care Provider _____

PAIN HISTORY

A) Chief Complaint (Reason for your visit today) _____

B) Does this pain radiate? If yes, where? _____

C) Please list any additional areas of pain: _____

If pain is in BOTH the Neck and Arm, please give a PERCENTAGE in each:

Neck:_____% Arm: Left_____% Right_____%

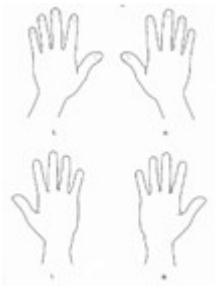
Please indicate (circle) the severity of the pain as it is most of the time (0=no pain, 10=worst pain)

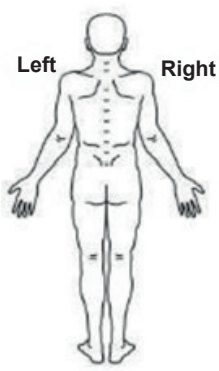
Neck: 0 1 2 3 4 5 6 7 8 9 10 Arm : 0 1 2 3 4 5 6 7 8 9 10

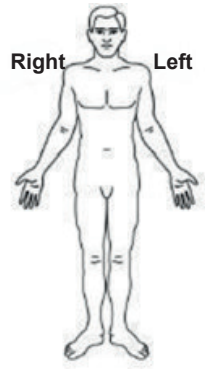
If "0" is no pain and "10" is the worst pain you can imagine, rate your pain on the table below:

Location	Pain right now	The worst it gets	The best It gets
Neck			
Arm			
Inter scap:			
Shoulder:			
Headache:			

D) Use this diagram to indicate the area of your pain and radiation. Mark the location with given symbol in the table below







- - -	Numbness
□□□	Pins and needles
○○○	Burning Pain
ΔΔΔ	Stabbing Pain
xxx	Aching Pain

E) Approximately when did this painbegin? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years.

F) What caused your current pain episode? ☐ Fall ☐ Vehicular Accident ☐ Lifting ☐ Don't Know

G) How did your current pain episode begin? ☐ Gradually ☐ Suddenly

H) Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

I) How often does the pain occur? ☐ Constantly-unrelated to activities

☐ Intermittent -unrelated to activities (Few times ☐ Every day / ☐ Every week / ☐ Every month).

☐ Only with activities ☐ Constantly present but aggravated by activities.

J) Check all the following that describe your pain: ☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins & Needles ☐ Tightness.

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K) When is your pain at its worst? ☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

L) What effect does each of the following have on your pain?

	Better	Worse	Same		Better	Worse	Same
Bending neck Backward	☐	☐	☐	Bending neck Forward	☐	☐	☐
Changes in Weather	☐	☐	☐	Morning	☐	☐	☐
Coughing/Sneezing	☐	☐	☐	Driving	☐	☐	☐
Lifting Objects	☐	☐	☐	Looking Upward	☐	☐	☐
Looking downward	☐	☐	☐	End of the day	☐	☐	☐
Sitting	☐	☐	☐	Standing	☐	☐	☐
Sleeping	☐	☐	☐	Hand over the head	☐	☐	☐

M) What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms

1. Numbness/ tingling/radiation of pain affects what part of arm and neck ?

	Right	Left	Bilateral		Right	Left	Bilateral
Neck	☐	☐	☐	Outside forearm	☐	☐	☐
Trapezius	☐	☐	☐	Thumb	☐	☐	☐
Shoulder	☐	☐	☐	Index finger	☐	☐	☐
Triceps	☐	☐	☐	Middle Finger	☐	☐	☐
Biceps	☐	☐	☐	Ring Finger	☐	☐	☐
Elbow	☐	☐	☐	Pinky Finger	☐	☐	☐
Inside forearm	☐	☐	☐	All fingers	☐	☐	☐
Other_____				Hand and Palm	☐	☐	☐

☐ Right ☐ Left ☐ Both

2. Weakness in the Arm: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Fingers ☐ Right ☐ Left ☐ Both
3. Joint Swelling/ Stiffness: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Fingers ☐ Right ☐ Left ☐ Both
4. Morning Stiffness in Neck: ☐ Yes ☐ No ☐ Lasts more than 30 min ☐ Less than 30 min
6. Fever Chills ☐ Yes ☐ No,Explain_____
7. Loss of bladder control ☐ Yes ☐ No, Explain _____
8. Loss of bowel control ☐ Yes ☐ No, Explain _____
9. Balance related problems ☐ Yes ☐ No, Explain _____
10. Change in handwriting ☐ Yes ☐ No, Explain _____
11. Change in fine motor skills like using fork and spoon ☐ Yes ☐ No, Explain_____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Office Use Only

Name: _____

Date: _____

SECTION 1 - Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginabel at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can message most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveninently placed, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights,but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

SECTION 4 - Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - Headaches ☐ I have no headaches at all. ☐ I have slight headaches, which come infrequently. ☐ I have moderate headaches, which come infrequently. ☐ I have moderate headaches, which come frequently. ☐ I have severe headaches, which come frequently. ☐ I have headaches almost all the time.	**SECTION 6 - Concentration.** ☐ I can concentrate fully when I want to with no difficulty. ☐ I can concentrate fully when I want to with slight difficulty. ☐ I have a fair degree difficulty in concentrating when I want to. ☐ I have a lot of difficulty in concentrating when I want to. ☐ I have a great deal of difficulty in concentrating when I want to. ☐ I cannot concentrate at all.
SECTION 7 - Work ☐ I can do as much work as I want to. ☐ I can do only my usual work, but no more. ☐ I cannot do my usual work. ☐ I can hardly do any work at all. ☐ I can't do any work at all.	**SECTION 8 - Driving** ☐ I can drive my car without any neck pain. ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck. ☐ I can't drive my car as long as I want because of moderate pain in my neck. ☐ I can't drive my car at all.
SECTION 9 - Sleeping ☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 1 hr sleepless) ☐ My sleep is middly disturbed (1-2 hrs sleepless) ☐ My sleep is moderately disturbed (2-3 hrs sleepless) ☐ My sleep is greatly disturbed (3-5 hrs sleepless) ☐ My sleep is completely disturbed (5-7 hrs sleepless)	**SECTION 10 - Recreation** ☐ I am able to engage in all my recreation activities with no neck pain at all. ☐ I am able to engage in all my recreation activities, with some pain in my neck. ☐ I am able to engage in most, but not all of my usual recreation activities, because of pain in my neck. ☐ I am able to engage in a few of my usual recreation activities, because of pain in my neck. ☐ I can hardly do any recreation activities because of pain in my neck. ☐ I can't do any recreation activities at all.

Score: _____/50 Transform to percentage score x 100 = _____% Points.
Scoring: For each section the total possible score is 5: If the first statement is marked the section score = 0, if the last statement is marked it = 5.
If all ten sections are completed the score is calculated as follows: Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated: 16 (total scored)
45 (total possible score) x 100 = 35.5 %

Minimum Detectable Change (90% confidence): 5 points or 10% points.

N) Please list all past pain medications that you have been on at any point for your current pain.

MEDICATION	DOSE	FREQUENCY	PERIOD APPROXIMATELY TAKEN	CURRENTLY TAKING	GOOD RELIEF	MODERATATE PAIN RELIEF	NO PAIN RELIEF	SIDE EFFECT EXPERIENCED

INTERVENTIONAL PAIN TREATMENT HISTORY

INTERVENTIONAL PAIN TREATMENT TYPE	REGION	NUMBER OF PROCDURES LAST YEAR	DATE OF THE LAST PROCEDURES	AMOUNT OF PAIN RELIEF MILD, MODERATE, EXCELLENT	SIDE EFFECT EXPERIENCED
EPIDURAL STEORID INJ					
FACET JOINT INJECTION					
SACROILIAC JOINT INJECTION					
MEDIAL BRANCH BLOCKS					
RFA					
SPINAL CORD STIMULATOR					
TRIGGER POINTS					
VERTEBROPLASTY/KYPHOPLASTY					

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Please mark all of the following you have used for pain relief

	Helped Pain	Worsened	No Change
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐
Spinal Cord Stimulator Trial	☐	☐	☐
Spinal Cord Stimulator Implant	☐	☐	☐

Other_____

Physical therapy Details

• Have you had physical therapy for this problem? ☐ No ☐ Yes Describe_____

• Did this therapy help? ☐ No ☐ Yes Describe_____

• Do you do any special exercises for your back or neck?_____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including date:

1) _____Date _____

2)_____Date _____

3)_____ Date_____

4)_____Date_____

5)_____Date_____

☐ I have NEVER had any surgical procedures performed.

CURRENT MEDICATIONS:

Are you currently taking any blood thinners or anti-coagulants?

☐ Yes ☐ No If Yes, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Xarelto ☐ Other_____

Please list all medications you are currently taking including vitamins but excluding the pain medications.

Medication Name	Dosage	Frequency

Mark all the following tests that you have related to your current pain complaints in the last year.

Investigation	Region	Recent dates	Region	Recent Dates
MRI				
CT scan				
X-rays				
EMG- NCV				
Vascular studies				
DEXA scan				
Myelogram				
Discogram				
PET Scan				

☐ Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

Specialty	Name	Treatments	Pain relief?	Last intervention Dates
☐ **Acupuncturist**				
☐ **Neurosurgeon**				
☐ **Psychiatrist/Psychologist**				
☐ **Chiropractor**				
☐ **Orthopedic Surgeon**				
☐ **Rheumatologist**				
☐ **Internist**				
☐ **Physical Therapist**				
☐ **Neurologist**				

☐ Other: _____

List the names of any previous pain management physicians you have seen in the past:

_____

PAST MEDICAL HISTORY

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer – Type_____

☐ Diabetes – Type I Type II Controlled? ☐ Yes ☐ No Blood Sugar Average weekly _____

Last Hb A1c _____ Any Diabetes related comorbidity_____

Head/Ears/Eyes/Nose/Throat ☐ Headaches ☐ Migraines ☐ Head Injury

☐ Hyperthyroidism ☐ Hypothyroidism ☐ Glaucoma

Cardiovascular/Hematologic-

☐ Anemia ☐ Heart Attack ☐ Coronary Artery Disease ☐ High Blood Pressure ☐ Peripheral Vascular Disease ☐ Stoke/TIA ☐ Heart Valve Disorders

Respiratory ☐ Asthma ☐ Bronchitis/Pneumonia ☐ Emphysema/COPD

Gastrointestinal ☐ GERD (Acid Reflux) ☐ Gastrointestinal Bleeding ☐ Stomach Ulcers ☐ Constipation

Musculoskeletal/Rheumatologic

☐ Bursitis ☐ Carpal Tunnel Syndrome ☐ Fibromyalgia ☐ Osteoarthritis

☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Chronic Joint Pains

Neuropsychological ☐ Multiple Sclerosis ☐ Peripheral Neuropathy ☐ Seizures ☐ Depression

☐ Anxiety ☐ Schizophrenia ☐ Bipolar Disorder

Urological ☐ Chronic kidney Disease ☐ Kidney Stones ☐ Urinary Incontinence ☐ Dialysis

ALLERGIES: Do you have any drug/medication allergies? ☐ Yes ☐ No If yes, please list all medications you are allergic to:

Medication Name Allergic Reaction please post type of reaction to the allergic medication as well.

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast-

Any other allergies, Adhesive tapes.

REVIEW OF SYSTEMS for Today

Constitutional: ☐ Chills ☐ Difficulty Sleeping ☐ Easy Bruising ☐ Night Sweats

☐ Fatigue ☐ Fevers ☐ Insomnia ☐ Low sex Drive

☐ Tremors ☐ Unexplained Weight Gain ☐ Unexplained Weight Loss ☐ Weakness

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Eyes:	☐ Recent Visual changes			
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems	☐ Nosebleeds
	☐ Sinus problems			
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots	☐ Fainting
	☐ Palpitations	☐ Swelling in feet	☐ Shortness of breath during sleep	
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath	
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps	☐ Diarrhea
	☐ Nausea/Vomiting	☐ Hernia		
Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness	☐ Joint Swelling
	☐ Muscle Spasms	☐ Neck Pain		
Genitourinary/Nephrology:		☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
		☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Numbness/Tingling	☐ Tremors
	☐ Seizures			
Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems	☐ Suicidal Thoughts
	☐ Suicidal Planning	☐ Thoughts of Harming Others		

☐ All other review of systems negative.

SOCIAL HISTORY

Are you: Married/Partnered/Single/Divorced/Separated/Widowed/Number of Children, if any:_____

Occupation: _____ When was the last time you worked?_____

Who is in your current household? _____

Are there any stairs in your current home? ☐ Yes ☐ No If yes, how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Date started: _____

Alcohol Use:	☐ Social Use	☐ History of Alcoholism	☐ Current Alcoholism	☐ Never
	☐ Daily use of alcohol			
Tobacco Use:	☐ Current User	☐ Former User	☐ Never used	☐ Packs per day? _____
	☐ How many years? _____		☐ Quit Date: _____	
Illegal Drug Use:	☐ Denies any illegal drug use		☐ Currently uses illegal drugs	
	☐ Formerly used illegal drugs			

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Headaches/Migraines
☐ High Blood Pressure	☐ Kidney Problems	☐ Liver Problems	☐ Osteoporosis
☐ Rheumatoid Arthritis	☐ Seizures	☐ Stroke	☐ Other Medical Problems: _____

_____

☐ I have no significant family medical history.

Patient Signature_____ Date _____

Reviewed by _____ Date _____

MD Signature_____ Date _____