

NAME: _____ DATE: _____

BIRTHDATE: _____ / _____ / _____ HEIGHT: _____ FT. _____ IN. WEIGHT _____ LBS

A. 1. Internist or family doctor name and address: _____

2. Chief complaint Neck pain Arm: Pain Numbness Weakness
(check all that apply) Back pain Leg: Pain Numbness Weakness
 Other: _____

3. Your age: _____ Years _____ Months

4. Your sex: Male Female

5. How long has the pain (or your problem) been present? _____

6. Has your problem worsened recently? No Yes – How recently? _____

7. What started the pain (or problem)? _____

B. For patients with NECK OR ARM pain, numbness, or weakness:

(If you are seeing the doctor for back or leg pain, please ask for the BACK OR LEG questionnaire.)

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

- Neck 0%, Arm 100% Neck 10%, Arm 90% Neck 25%, Arm 75%
 Neck 40%, Arm 60% Neck 50%, Arm 50% Neck 65%, Arm 40%
 Neck 75%, Arm 25% Neck 90%, Arm 10% Neck 100%, Arm 0%

2. There is: No arm pain Arm pain is as follows (check the following):

- a. Right 0%, Left 100% Right 10%, Left 90% Right 25%, Left 75%
 Right 40%, Left 60% Right 50%, Left 50% Right 65%, Left 40%
 Right 75%, Left 25% Right 90%, Left 10% Right 100%, Left 0%

b. The arm pain is present in the (check the following):

Right: Upper back Shoulder Upper arm Forearm Hand/finger

Left: Upper back Shoulder Upper arm Forearm Hand/finger

3. Raising the arm: Improves the pain Worsens the pain Does not affect the pain

4. Moving the neck: Improves the pain Worsens the pain Does not affect the pain

5. There is: No weakness of the arms and hands Weakness of the (check the following):

Right: Shoulder Upper arm Forearm Hand/finger

Left: Shoulder Upper arm Forearm Hand/finger

6. There is: No numbness of the arms and hands Numbness of the (check the following):

Right: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger

Left: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger

7. There (is is not) difficulty picking up small objects like coins or buttoning buttons.

8. There (is is not) problem with balance or tripping frequently

9. There are (Frequent Occasional No) headaches in the back of the head.

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- C.** 1. Coughing or sneezing (Increases Sometimes increases Does not increase) the pain.
 2. There is: No loss of bowel or bladder control Loss of bowel or bladder control since _____
 3. I have: Not missed any work because of this problem Missed (how much?) _____ work.
 4. Treatments have included: No medicines, therapy, manipulations, injections, or braces.

- | | | | | | |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---|
| Neck | Back | | Neck | Back | |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy, exercise | <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Massage & ultrasound | <input type="checkbox"/> | <input type="checkbox"/> | Narcotic medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Traction | <input type="checkbox"/> | <input type="checkbox"/> | Epidural steroid injections ___times which
relieved the pain for (how long?) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Manipulation | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS unit | <input type="checkbox"/> | <input type="checkbox"/> | Trigger point injections ___times which
relieved the pain for (how long?) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injections | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Braces | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

5. List pain medications and dose taken for your spine problem: None

Medication	Dose

6. Previous doctors seen about this problem: None

Doctor	Specialty	City (if not New York)	Treatments

D. MEDICAL HISTORY

Please check all that apply None apply

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> AIDS | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> Loose, capped,
missing, or chipped
teeth |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Serious injuries:
_____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Stomach ulcers | |
| <input type="checkbox"/> Ulcers or hiatus hernia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Glasses
or contact lenses | |
| <input type="checkbox"/> Dentures/Bridges | <input type="checkbox"/> Problems with hearing | | |
| <input type="checkbox"/> Other: _____ | | | |

- E. SURGICAL HISTORY:** Previous surgeries- list procedure, surgeon, and date. None

OPERATION	SURGEON	DATE

- F. MEDICATIONS YOU TAKE:** None

G. ALLERGIES TO MEDICATIONS: No known drug allergies

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

H. SOCIAL HISTORY

1. Work status: Homemaker Retired Disabled On leave
 Unemployed Working: __ Full time __ Part time
Occupation: _____
2. Marital status: Married Single Co-habiting
 Widowed Divorced
3. Number of living children: _____
4. I live: Alone With: _____
5. Tobacco use: Never (skip to #6)
 Cigar Chew Pipe Cigarettes
_____ packs per day for _____ years.
 Quit – When? _____ after smoking
_____ packs per day for _____ years (total).
6. Alcohol: Never or rare
 Social Frequently drunk (more than twice a week)
 Alcoholic Recovering alcoholic
7. Drug use/abuse: Never Currently In the past
8. Because of this spine problem, I have filed or plan to file:
 A lawsuit A Worker’s Compensation claim
 Neither a lawsuit nor a Worker’s Compensation claim

I. FAMILY HISTORY: Check all that apply. None apply

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney trouble or stones | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Bleeding disorders | _____ |

J. REVIEW OF SYSTEMS

1. Do you have any problems with your **HEART** or **CIRCULATION**? Check all that apply
 Heart murmur or Mitral Valve Prolapse Irregular Heartbeat
 Difficulty with Stairs (due to shortness of breath) Sleeping on more than one pillow
 Waking at night with shortness of breath Ankle Swelling
 Shortness of breath at rest or exercising Chest pain at rest or exercising

If yes, please explain: _____

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2. Do you have any problems with your **LUNGS** or **BREATHING**? Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Cough or Coughing up phlegm | <input type="checkbox"/> Shortness of breath |

If yes, please explain: _____

3. Do you have any problems with your **BLOOD**? Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Bleeding tendency or easy bruising | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Blood transfusions | |

If yes, please explain: _____

4. Do you have any problems with your **NERVES, MUSCLES** or **BONES**? Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of sensation |
| <input type="checkbox"/> Paralysis or weakness of limbs | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Loss of coordination | <input type="checkbox"/> Muscle wasting |
| <input type="checkbox"/> Head, neck, or back injury | <input type="checkbox"/> Psychiatric illness |
| <input type="checkbox"/> Extreme nervousness or anxiety | |

If yes, please explain: _____

Are you pregnant? Yes No Date of last menstrual period: _____

MY PAIN/DISCOMFORT IS (circle number)

0	1	2	3	4	5	6	7	8	9	10
No pain	Slight	Mild	Moderate	Severe	Excruciating	Pain as bad as it could be				

Patient signature

Date

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NECK DISABILITY INDEX

Please read: This questionnaire has been designed to give the doctor 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 which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

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 imaginable 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 manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficult 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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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 lift very light weights.
- I cannot lift or carry anything at all.

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 to with moderate pain in my neck
- I can't read as much as I want because of 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 of 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 only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot 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 cannot drive my car as long as I want because of Pain in my neck
- I can hardly drive at all because of severe pain in my neck

Section 9 – Sleeping

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

Section 10 – Recreation

- I am able to engage in all my recreational activities with no neck pain at all
- I am able to engage in all my recreational activities with some pain in my neck
- I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
- I am able to engage in few of my usual recreational activities because of pain in my neck
- I can hardly do any recreational activities because of pain in my neck
- I cannot do any recreational activities at all