CERVICAL SPINE APPOINTMENT

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NAME _____

Please circle and/or fill in the answers to the following questions on all pages.

Who referred you to our office? _____

Who is your family physician? _____

Other physicians who should receive correspondence about today's visit? _____

Age _____ Gender _____ Occupation _____

Is this a **work related** injury? Yes No

Main Complaint: What is your main complaint?

____**Neck pain**
____**Arm pain** Right Left Both
____**Both Arms** which arm is worse? Right or Left

Have you had **previous cervical spinal surgery?** Yes No

Duration of symptoms

How long have you had neck pain? _____
How long have you had arm pain? _____
Are the symptoms **episodic** or **constant**? **(Circle one)**
Since the onset of the current symptoms, you feel: Better Worse Same

Does the Arm Pain travel down your arm? Yes No

Arm Weakness? Yes No Which arm? Right Left

Description of pain (circle all that apply)

Arm pain: Sharp Dull Aching Burning Stabbing Electrical

- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your arm pain at its:
  Worst_____ Usually _____
- **Does the arm pain wake you up at night?** Yes No
- **Arm symptoms worsen with:** Athletic activity Driving Walking Standing Sitting Lying down
- **Arm symptoms improve with:** Athletic activity Driving Walking Standing Sitting Lying down
- **Numbness and Tingling down the arm?** Yes No
- **Do you have difficulty with your handwriting?** Yes No
- **Do your hands feel clumsy?** Yes No
- **Do you have problems with your balance?** Yes No
- **Any recent falls because of poor balance?** Yes No

Neck Pain (circle all that apply): Sharp Dull Aching Burning Stabbing Electrical

- Neck pain: **constant** or **comes and goes**
- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your neck pain at its:
  Worst _____ Usually _____
- Does the neck pain wake you up at night? Yes No
- Neck symptoms worsen with: Athletic activity Driving Walking Standing Sitting Lying down
- Neck symptoms are improved with: Lying down Sitting Walking Other _____

Exercise routine: _____ days per week. What type of exercise? _____

Do you have difficulty walking or standing? Yes No

Bladder problems:
Do you suffer from urinary incontinence? Yes No Date it started: _____

Treatment for this problem thus far:

What **Medications** are you **currently** taking for the pain? **What dose and how often?**
1. 4.
2. 5.

Have you ever had **Cervical Epidural Steroid Injections**?

Have you undergone any **Physical Therapy** for this condition? Yes No
Did physical therapy help? Yes No
When was your last session of Physical Therapy? _____ (Date)

Have you used a **neck brace**? Yes No Did it help? Yes No
What **other treatments** have you had?
__Chiropractic __Acupuncture __Massage __TENS unit Other _____

SOCIAL HISTORY:
Do you smoke? No Yes _____ How many packs per day?
Do you drink alcohol? No Yes _____ How much per day?

Are you currently taking any blood thinning medications? Yes No
Blood thinner: _____

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.
1. 3.
2. 4.

ADDITIONAL INFORMATION: