NECK PAIN
NEW PATIENT HISTORY

Patient Name_____

In order to properly assess your condition, we must understand how much your NECK/ARM problems has affected your ability to manage everyday activities. For each item below, please circle the answer which most closely describes your present condition. (R = Right, L = Left, B = Both)

LOCATION OF PAIN (CERVICAL PAIN RADIATION) ❑ **NONE**

CERVICAL

Neck	Shoulders	Shoulder Blades	Upper Arm	Lower Arm	Hands
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE IS MORE PAINFUL? (CERVICAL PAIN SIDE) ❑ **RIGHT** ❑ **LEFT** ❑ **EQUAL** ❑ **NOT APPLICABLE (N/A)**

LOCATION OF NUMBNESS OR TINGLING (CERVICAL NUMBNESS LOCATION) ❑ **NONE**

CERVICAL

Neck	Shoulders	Shoulder Blades	Upper Arm	Lower Arm	Hands
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE HAS LESS SENSATION? (CERVICAL NUMBNESS SIDE) ❑ **RIGHT** ❑ **LEFT** ❑ **EQUAL** ❑ **NOT APPLICABLE (N/A)**

LOCATION OF WEAKNESS (CERVICAL WEAKNESS LOCATION) ❑ **NONE**

CERVICAL

Neck	Shoulders	Shoulder Blades	Upper Arm	Lower Arm	Hands
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE IS WEAKER? (CERVICAL WEAKNESS SIDE) ❑ **RIGHT** ❑ **LEFT** ❑ **EQUAL** ❑ **NOT APPLICABLE (N/A)**

WHEN DID YOUR NECK/ARM PAIN BEGIN? (CERVICAL PAIN ONSET) _____

WHAT CAUSED YOUR PRESENT NECK/ARM PAIN TO START? (CERVICAL PAIN CAUSE)

❑ **Started Gradually** ❑ **Work Injury** ❑ **Motor Vehicle Accident** ❑ **Personal Injury** ❑ **No injury, Woke up with it** ❑ **Other**

IF YOUR NECK PAIN STARTED AFTER AN INJURY, PLEASE DESCRIBE BRIEFLY. (CERVICAL INJURY DETAILS)

_____

_____

_____

HOW WOULD YOU DESCRIBE YOUR NECK/ARM PAIN? (CERVICAL PAIN CHARACTER)

❑ **DULL** ❑ **SHARP** ❑ **THROBBING** ❑ **NAGGING** ❑ **PRESSURE**
❑ **ACHING** ❑ **SHOOTING** ❑ **BURNING** ❑ **STABBING** ❑ **OTHER**

ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF NECK PAIN? (NECK PAIN INTENSITY)

Current Level: ____/10; Highest Level Past 24 HRS: ____/10; Lowest Level Past 24 HRS: ____ /10; Average Level: ____/10

ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF ARM PAIN? (ARM PAIN INTENSITY)

Current Level: ____/10; Highest Level Past 24 HRS: ____/10; Lowest Level Past 24 HRS: ____ /10; Average Level: ____/10

HOW LONG HAS THE CURRENT EPISODE OF NECK/ ARM PAIN BEEN PRESENT? (CERVICAL PAIN DURATION)

❑ Just Started	❑ 1-14 Days	❑ 2-4 Weeks	❑ 4-8 Weeks	❑ 2-3 Months	❑ 3-6 Months	❑ 6-9 Months	❑ 9-12 Months	❑ Years

WHAT PORTION OF THE AVERAGE DAY DO YOU HAVE NECK/ARM PAIN? (CERVICAL PAIN FREQUENCY)

❑ None (0%/Day)	❑ Occasional (25%/Day)	❑ Intermittent (50%/Day)	❑ Frequent (75%/Day)	❑ Constant (100%/Day)

WHAT TIME OF DAY IS THE NECK/ARM PAIN THE MOST SEVERE? (CERVICAL PAIN TIMING)

❑ Mornings	❑ End of the day	❑ After activity	❑ Varies	❑ Constant	❑ With Sleep

HOW HAVE THE EPISODES OF NECK/ARM PAIN CHANGED SINCE THEY STARTED? (CERVICAL PAIN EVOLUTION)

❑ Worsening	❑ Slightly Worse	❑ Unchanged	❑ Slightly Improved	❑ Improving

DO YOU HAVE LIMITED MOVEMENT OF THE NECK OR STIFFNESS? (CERVICAL MOTION)

❑ None	❑ Mild Stiffness	❑ Moderate Stiffness	❑ Severe Stiffness

DO YOU HAVE NECK MUSCLE SPASMS? (CERVICAL MUSCLE SPASMS)

❑ None	❑ Mild Spasms	❑ Moderate Spasms	❑ Severe Spasms

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR NECK AND ARM PAIN? (NECK/ARM PAIN RATIO) ❑ **NONE**

❑ Only the Neck hurts 100%Neck /0%Arm	❑ Neck hurts much more than Arm 90%Neck/10%Arm	❑ Neck hurts a little more than Arm 75%Neck/25%Arm	❑ Neck hurts about the same as Arm 50%Neck/50%Arm	❑ Neck hurts a little less than Arm 25%Neck/75%Arm	❑ Neck hurts much less than Arm 10%Neck/90%Arm	❑ Only the Arm hurts 0%Neck /100% Arm

NECK PAIN AGGRAVATION/RELIEF

WHAT TENDS TO MAKE THE NECK/ARM PAIN WORSE? (CERVICAL PAIN AGGRAVATION) ❑ **NONE**

Bending	Twisting	Lifting	Work	Activity	Recreation	Overhead Work
Sitting	Standing	Walking	Reading	Computer	Sleeping	Laying Down
Stress	Cough/Sneeze	Vibration	Driving/Travel	Housework	Bowel Movement	Weather Change

OTHER-_____

WHAT TENDS TO MAKE THE NECK/ARM PAIN BETTER? (CERVICAL PAIN RELIEF) ❑ **NONE**

Heat	Ice	Rest/Inactivity	Certain Positions	Laying Down	Activity	Walking
Medication	Therapy	Stretching	Injections	Massage	Soft Collar	TENS
Change Pillow	Chiropractic	Arm Elevation	Traction	Other		

OTHER-_____

PAST EPISODES OF NECK PAIN

HOW MANY TIMES HAVE YOU BEEN TREATED FOR NECK/ARM PAIN IN THE PAST? (NUMB OF PRIOR EPISODES CERV PAIN)

❑ None	❑ A Few	❑ Several	❑ Many	❑ Constant

HOW LONG AGO WAS THE LAST EPISODE OF NECK/ARM PAIN? (TIME SINCE PRIOR EPISODE CERVICAL PAIN)

❑ None	❑ Days	❑ Weeks	❑ Months	❑ Years	❑ Constant

HOW LONG DID THE LAST EPISODE OF NECK/ARM PAIN LAST? (DURATION OF PRIOR EPISODES CERVICAL PAIN)

❑ None	❑ Days	❑ Weeks	❑ Months	❑ Years	❑ Constant

HOW HAVE THE EPISODES OF NECK/ARM PAIN CHANGED SINCE THEY STARTED? (FREQUENCY OF PRIOR EPISODES)

❑ None	❑ Much More Often	❑ Slightly More Often	❑ No Change in Frequency	❑ Slightly Less Often	❑ Much Less Often

GAIT AND BALANCE SYMPTOMS

DO YOU HAVE ANY PROBLEMS WALKING ? (GAIT DISTURBANCE SEVERITY)

❑ No Problem Walking	❑ Mild Problem Walking	❑ Moderate Problem Walking	❑ Severe Problem Walking

HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR WALKING? (GAIT DISTURBANCE DURATION)

❑ N/A	❑ A Few Days	❑ A Few Weeks	❑ A Few Months	❑ 6 Months or More	❑ One year or More

DO YOU HAVE PROBLEMS WITH YOUR BALANCE, SUCH AS FREQUENT FALLING? (BALANCE SYMPTOMS SEVERITY)

❑ No Balance Problems	❑ Mild Balance Problems	❑ Moderate Balance Problems	❑ Severe Balance Problems

HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR BALANCE OR COORDINATION? (BALANCE DURATION)

❑ N/A	❑ A Few Days	❑ A Few Weeks	❑ A Few Months	❑ 6 Months or More	❑ One year or More

DO YOU USE ANY DEVICES TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES)

❑ None	❑ Cane	❑ Crutches	❑ Walker	❑ Wheelchair	❑ Scooter

HOW LONG HAVE YOU USED THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES DURATION)

❑ N/A	❑ A Few Days	❑ A Few Weeks	❑ A Few Months	❑ 6 Months or More	❑ One year or More

WHY DO YOU USE THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES NECESSITY)

❑ N/A	❑ To Relieve Stress on the Back	❑ For Weak Leg(s)	❑ For Balance Problems	❑ Other .

WORK STATUS

ARE YOU WORKING AT THIS TIME? (WORK STATUS)

❑ Yes –Full Duty	❑ Yes – with Restrictions	❑ Not Working - due to illness	❑ Not Working– by choice	❑ Unemployed	❑ Retired	❑ Disabled

NECK PAIN
NEW PATIENT HISTORY

ASSOCIATED SYMPTOMS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (SYSTEMIC SYMPTOMS)

frequent fevers or chills	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)
generalized weakness or fatigue	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)
unplanned weight loss greater than 10 lbs	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)
recent trauma, fall or accident	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)
night pain that wakes you up from sleep	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)
night pain that stops you from falling asleep	❑NO	❑YES	❑NEW (<1MONTH)	❑OLD (>1MONTH)

DO YOU HAVE PROBLEMS WITH THE USE OF YOUR HANDS OR HAND CLUMSINESS SUCH AS DIFFICULTY BUTTONING BUTTONS, TYING SHOES OR WRITING? (HAND DEXTERITY)

❑ No Hand Problems	❑ New Hand Problems for LESS THAN 1 Month	❑ Old Hand Problems for MORE THAN 1 Month

HOW SEVERE ARE THE PROBLEMS WITH THE USE OF YOUR HANDS OR HAND CLUMSINESS? (HAND DEXTERITY SEVERITY)

❑ N/A	❑ Mild Hand Problems	❑ Moderate Hand Problems	❑ Severe Hand Problems

DO YOU HAVE HEADACHES THAT ARE MAINLY LOCATED AT THE BASE OF YOUR SKULL AND SEEM TO BE RELATED TO YOUR NECK PAIN? (CERVICOGENIC SYMPTOMS)

❑ No	❑ Yes	❑ I have other types of headaches that cause pain in other areas

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CTS SYMPTOMS)

❑ **wrist pain that may travel up to the forearm**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **poor grip strength**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **constantly dropping items**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **numbness or tingling in the fingers with use**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **numbness or tingling in the fingers when you get up in the morning**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **shaking the hands to get feeling back into the fingers**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CUBITAL TUNNEL SYMPTOMS)

❑ **numbness that travels down the forearm to the small and ring fingers**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **pain that travels from the elbow down the forearm to the small and ring fingers**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (IMPINGEMENT SYMPTOMS)

❑ **pain in the front of the shoulder**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **pain when laying on the shoulder to sleep**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **stiffness or limited shoulder motion**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **shoulder pain that limits the ability to lift or reach overhead**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)
❑ **shoulder weakness that limits the ability to lift or reach overhead**	❑ NO	❑ YES	❑ NEW (<1MONTH)	❑ OLD (>1MONTH)

Please Read: This questionnaire is designed to give the doctor information as to how your neck/arm 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 may relate 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 the worst imaginable at the moment.

Section 2 – Personal Care
- ❑ 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 everyday in most aspects of health care.
- ❑ I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting (Skip if you have not attempted lifting since the onset of your neck pain).
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g. on a table)
- ❑ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only 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 cannot 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 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 neck pain.
- ❑ I can drive my car as long as I want with moderate neck pain.
- ❑ I cannot drive my car as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping
- ❑ I have no trouble 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 (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours 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 recreational activities, with some neck pain.
- ❑ 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 neck pain.
- ❑ I can hardly do any recreation activities because of neck pain.
- ❑ I cannot do any recreation activities at all.

RAW Score X 2 = Oswestry Cervical Pain Disability Score
0-20 – mild; 20-40 – moderate; 40-60 – severe; >60 – very severe.

PAST CERVICAL SPINE TREATMENT

Diagnostic Tests

IN THE PAST SIX MONTHS HAVE YOU HAD ANY DIAGNOSTIC TESTING DONE ON YOUR NECK?

❑ Back X-ray	❑ Back MRI	❑ CT-Myelogram	❑ EMG/NCV Nerve Test	❑ Discogram	❑ Bone Scan	❑ Bone Density

Past Treatments

IN THE PAST SIX MONTHS HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR NECK/ARM CONDITION?

❑ Medications ❑ Helped	❑ Physical Therapy ❑ Helped	❑ Massage Therapy ❑ Helped	❑ Neck Brace ❑ Helped
❑ Chiropractic ❑ Helped	❑ TENS Unit ❑ Helped	❑ Epidural Injections (ESI's) ❑ Helped	❑ Other

Medications

PLEASE LIST ALL MEDICATIONS YOU <u>HAVE TAKEN</u> FOR YOUR NECK/ARM CONDITION IN THE PAST SIX MONTHS.

PLEASE LIST ALL MEDICATIONS YOU ARE <u>CURRENTLY</u> TAKING FOR YOUR NECK/ARM CONDITION.

Physical Therapy

Have you been treated with <u>PHYSICAL THERAPY</u> for your NECK/ARM condition? ❑ **YES** ❑ **NO**

When did you go to <u>PHYSICAL THERAPY</u> for your NECK/ARM condition? _____

How long did you go to <u>PHYSICAL THERAPY</u> for your NECK/ARM condition? _____

Epidural Injections

Have you been treated with <u>EPIDURAL STEROID INJECTIONS</u> for your NECK/ARM condition? ❑ **YES** ❑ **NO**

How many <u>EPIDURAL STEROID INJECTIONS</u> have you had for your NECK/ARM condition? _____

When was the last <u>EPIDURAL STEROID INJECTIONS</u> for your NECK/ARM condition? _____

How long do the <u>EPIDURAL STEROID INJECTIONS</u> usually last for your NECK/ARM condition? _____

Surgery

PLEASE LIST ANY PREVIOUS NECK SURGERY. PLEASE INCLUDE DATES, HOSPITAL, CITY AND PHYSICIAN IF KNOWN.

DID THE SURGERY HELP YOUR NECK/ARM CONDITION?

DID YOU HAVE ANY COMPLICATIONS WITH YOUR NECK SURGERY?