

**NECK PAIN
NEW PATIENT HISTORY**

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)

<input type="checkbox"/> Just Started	<input type="checkbox"/> 1-14 Days	<input type="checkbox"/> 2-4 Weeks	<input type="checkbox"/> 4-8 Weeks	<input type="checkbox"/> 2-3 Months	<input type="checkbox"/> 3-6 Months	<input type="checkbox"/> 6-9 Months	<input type="checkbox"/> 9-12 Months	<input type="checkbox"/> Years
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WHAT PORTION OF THE AVERAGE DAY DO YOU HAVE NECK/ARM PAIN? (CERVICAL PAIN FREQUENCY)

<input type="checkbox"/> None (0%/Day)	<input type="checkbox"/> Occasional (25%/Day)	<input type="checkbox"/> Intermittent (50%/Day)	<input type="checkbox"/> Frequent (75%/Day)	<input type="checkbox"/> Constant (100%/Day)
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WHAT TIME OF DAY IS THE NECK/ARM PAIN THE MOST SEVERE? (CERVICAL PAIN TIMING)

<input type="checkbox"/> Mornings	<input type="checkbox"/> End of the day	<input type="checkbox"/> After activity	<input type="checkbox"/> Varies	<input type="checkbox"/> Constant	<input type="checkbox"/> With Sleep
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HOW HAVE THE EPISODES OF NECK/ARM PAIN CHANGED SINCE THEY STARTED? (CERVICAL PAIN EVOLUTION)

<input type="checkbox"/> Worsening	<input type="checkbox"/> Slightly Worse	<input type="checkbox"/> Unchanged	<input type="checkbox"/> Slightly Improved	<input type="checkbox"/> Improving
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DO YOU HAVE LIMITED MOVEMENT OF THE NECK OR STIFFNESS? (CERVICAL MOTION)

<input type="checkbox"/> None	<input type="checkbox"/> Mild Stiffness	<input type="checkbox"/> Moderate Stiffness	<input type="checkbox"/> Severe Stiffness
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DO YOU HAVE NECK MUSCLE SPASMS? (CERVICAL MUSCLE SPASMS)

<input type="checkbox"/> None	<input type="checkbox"/> Mild Spasms	<input type="checkbox"/> Moderate Spasms	<input type="checkbox"/> Severe Spasms
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WHICH OF THE FOLLOWING BEST DESCRIBES YOUR NECK AND ARM PAIN? (NECK/ARM PAIN RATIO) NONE

<input type="checkbox"/> Only the Neck hurts 100%Neck /0%Arm	<input type="checkbox"/> Neck hurts much more than Arm 90%Neck/10%Arm	<input type="checkbox"/> Neck hurts a little more than Arm 75%Neck/25%Arm	<input type="checkbox"/> Neck hurts about the same as Arm 50%Neck/50%Arm	<input type="checkbox"/> Neck hurts a little less than Arm 25%Neck/75%Arm	<input type="checkbox"/> Neck hurts much less than Arm 10%Neck/90%Arm	<input type="checkbox"/> Only the Arm hurts 0%Neck /100% Arm
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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)

<input type="checkbox"/> None	<input type="checkbox"/> A Few	<input type="checkbox"/> Several	<input type="checkbox"/> Many	<input type="checkbox"/> Constant
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HOW LONG AGO WAS THE LAST EPISODE OF NECK/ARM PAIN? (TIME SINCE PRIOR EPISODE CERVICAL PAIN)

<input type="checkbox"/> None	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months	<input type="checkbox"/> Years	<input type="checkbox"/> Constant
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HOW LONG DID THE LAST EPISODE OF NECK/ARM PAIN LAST? (DURATION OF PRIOR EPISODES CERVICAL PAIN)

<input type="checkbox"/> None	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months	<input type="checkbox"/> Years	<input type="checkbox"/> Constant
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HOW HAVE THE EPISODES OF NECK/ARM PAIN CHANGED SINCE THEY STARTED? (FREQUENCY OF PRIOR EPISODES)

<input type="checkbox"/> None	<input type="checkbox"/> Much More Often	<input type="checkbox"/> Slightly More Often	<input type="checkbox"/> No Change in Frequency	<input type="checkbox"/> Slightly Less Often	<input type="checkbox"/> Much Less Often
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GAIT AND BALANCE SYMPTOMS

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

<input type="checkbox"/> No Problem Walking	<input type="checkbox"/> Mild Problem Walking	<input type="checkbox"/> Moderate Problem Walking	<input type="checkbox"/> Severe Problem Walking
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HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR WALKING? (GAIT DISTURBANCE DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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DO YOU HAVE PROBLEMS WITH YOUR BALANCE, SUCH AS FREQUENT FALLING? (BALANCE SYMPTOMS SEVERITY)

<input type="checkbox"/> No Balance Problems	<input type="checkbox"/> Mild Balance Problems	<input type="checkbox"/> Moderate Balance Problems	<input type="checkbox"/> Severe Balance Problems
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HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR BALANCE OR COORDINATION? (BALANCE DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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DO YOU USE ANY DEVICES TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES)

<input type="checkbox"/> None	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Scooter
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HOW LONG HAVE YOU USED THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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WHY DO YOU USE THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES NECESSITY)

<input type="checkbox"/> N/A	<input type="checkbox"/> To Relieve Stress on the Back	<input type="checkbox"/> For Weak Leg(s)	<input type="checkbox"/> For Balance Problems	<input type="checkbox"/> Other
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WORK STATUS

ARE YOU WORKING AT THIS TIME? (WORK STATUS)

<input type="checkbox"/> Yes -Full Duty	<input type="checkbox"/> Yes - with Restrictions	<input type="checkbox"/> Not Working - due to illness	<input type="checkbox"/> Not Working- by choice	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired	<input type="checkbox"/> Disabled
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ASSOCIATED SYMPTOMS

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

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

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

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

<input type="checkbox"/> numbness that travels down the forearm to the small and ring fingers	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
<input type="checkbox"/> pain that travels from the elbow down the forearm to the small and ring fingers	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

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

<input type="checkbox"/> pain in the front of the shoulder	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
<input type="checkbox"/> pain when laying on the shoulder to sleep	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
<input type="checkbox"/> stiffness or limited shoulder motion	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
<input type="checkbox"/> shoulder pain that limits the ability to lift or reach overhead	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
<input type="checkbox"/> shoulder weakness that limits the ability to lift or reach overhead	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> 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?

<input type="checkbox"/> Back X-ray	<input type="checkbox"/> Back MRI	<input type="checkbox"/> CT-Myelogram	<input type="checkbox"/> EMG/NCV Nerve Test	<input type="checkbox"/> Discogram	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Bone Density
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Past Treatments

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

<input type="checkbox"/> Medications <input type="checkbox"/> Helped	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Helped	<input type="checkbox"/> Massage Therapy <input type="checkbox"/> Helped	<input type="checkbox"/> Neck Brace <input type="checkbox"/> Helped
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Helped	<input type="checkbox"/> TENS Unit <input type="checkbox"/> Helped	<input type="checkbox"/> Epidural Injections (ESI's) <input type="checkbox"/> Helped	<input type="checkbox"/> Other

Medications

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

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

Physical Therapy

Have you been treated with PHYSICAL THERAPY for your NECK/ARM condition? YES NO

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

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

Epidural Injections

Have you been treated with EPIDURAL STEROID INJECTIONS for your NECK/ARM condition? YES NO

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

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

How long do the EPIDURAL STEROID INJECTIONS 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?

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DID YOU HAVE ANY COMPLICATIONS WITH YOUR NECK SURGERY?

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