Cervical Spine (Neck Pain)

Please fill in or circle as appropriate

Patient Name: _____ Date of Birth: _____

Who referred you to our office?

Who is your family physician?

What other physicians have you seen for this problem?

What is your age: Gender? Male Female

Date of injury/onset of illness?

On the date of injury/illness what was your job title or description?

On the date of injury/illness what were your usual work activities?

Have you missed work because of your injury/illness?
If yes, when did you first miss work?

Are you currently working?
If yes, when did you return to work?

Did you return to usual or limited work activities?

When did the symptoms first appear?

Main Complaint

What is your main complaint? Neck or arm pain?
If Arm pain, which arm? Left Right Both
If arm pain, which is worse? Left Right
Does the pain travel down your arm? Yes No
If yes, which arm? Left Right Both

Did you have any injuries or events leading to the onset of pain? Yes No
If yes, please elaborate

Patient Name: _____ Date of Birth: _____

If arm pain is worse, how would you break down the percentage vs. neck pain?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If neck pain is worse, how would you break down the percentage vs. arm pain?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs 40 50 vs 50

Duration of symptoms

How long have you had back and/or leg pain? ___yrs. ___mos. ___wks.
Are the symptoms episodic? Yes No How many episodes per year?
The current episode has been for how long?

Motor Vehicle Collision? Yes No
Date of accident: _____
Did you wear a seat belt? Yes No
You were the: Driver Passenger (Front or Back seat)
Collision: Rear End Front End Side Impact
Speed estimate:
Damage to your car: $_____ Totaled?

Description of Pain

Arm Pain: Sharp Dull Aching Burning Stabbing Electrical
Arm Pain: Constant or Comes and Goes
Pain intensity on a scale of 1 – 10 (10 most severe):
Does pain wake you up at night? Yes No
Can you live with the pain? Yes No
What worsens the pain? Athletics Driving Walking Standing/Sitting
Pins and Needles Sensation down arm? Yes No
Numbness and Tingling down the arm? Yes No
Arm pain worse with coughing or sneezing? Yes No
Arm pain improve with arm on top of your head? Yes No
Difficulty writing? Yes No Difficulty picking up small coins off a table? Yes No
Trouble buttoning buttons? Yes No Do your hands feel clumsy? Yes No
Do you have problems with balance? Yes No

Neck Pain: Sharp Dull Aching Burning Stabbing
Neck Pain: Constant or Comes and Goes
Pain intensity on a scale of 1 – 10 (10 most severe):
Does pain wake you up at night? Yes No
Can you live with the pain? Yes No
Neck pain worse with: Athletics Driving Walking Standing Sitting
Neck pain improved with: Lying down Sitting Walking

Patient Name: _____ Date of Birth: _____

Activities

Do you exercise? Yes No

Routine: Treadmill Bike Swim Weights

Sports: Golf Tennis Basketball Other: _____

Walking:

Unlimited 1-2 blocks Less than ½ block Not able to walk

Assist: Cane Walker Wheelchair

Arm Weakness? Yes No Which arm? Right Left Both

Bladder problems? Yes No

Treatment thus far:

Medications:

Anti-inflammatories: Advil Aleve Mobic Celebrex Relafen

Narcotics: Tylenol #3 Darvocet Vicodin Percocet Oxycontin

Muscle Relaxants : Flexiril Skelaxin Valium Soma

Other : Neurontin Lyrica Cymbalta Elavil

Other pain meds: _____

For how long have you used pain meds?

Have you had any prior treatment for your back/leg pain? Yes No

If yes,

Physical Therapy?

Where and When?

Chiropractic?

Acupuncture:

Epidural injections?

How many? _____ When was last injection? _____

Have you visited a surgeon for this problem before? Yes No

What was the recommendation?

Any recent emotionally traumatic events?

***Patient Name:* _____ *Date of Birth:* _____**

PAST MEDICAL HISTORY – Please list

1.	2.	3.
4.	5.	6.
7.	8.	9.

Other _____

PAST SURGICAL HISTORY – Please list

1.	2.	3.
4.	5.	6.
7.	8.	9.

Other _____

MEDICATIONS (non-pain) – Please list

1.	2.	3.
4.	5.	6.
7.	8.	9.

Are you currently taking: Coumadin? Plavix? Aspirin?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin
Other ---

SOCIAL HISTORY:

Where do you live?
With whom do you live?
Smoke: No Yes ---- How many packs per day? _____
Alcohol: No Yes ---- How much per day? _____
Drugs: No Yes ---- What types? _____

FAMILY HISTORY:

Spine surgery? _____ Stenosis? _____ Neck or Back problems? _____
Major medical diseases? _____

REVIEW OF SYSTEMS: Recent problems with any of the following?

☐ Constitutional: Fevers Chills Weight Loss ☐ Eyes, Ears, Nose, Throat
☐ Cardiovascular ☐ Respiratory ☐ Gastrointestinal
☐ Musculoskeletal ☐ Skin ☐ Breast ☐ Neurologic
☐ Psych ☐ Endrocine ☐ Heme/Lymph