Eric W. Hooley, M.D.
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Patient Name:________________________________ Age:_______ Date:________________

Please complete all questions. All responses will remain confidential.

1. What is the main reason for your visit?

☐ Neck pain ☐ Arm pain ☐ Other:____

2. How long have you had this pain?

☐ _______ days ☐ _______ month(s) ☐ _______ year(s)

3. Please mark where your pain is on the diagram below:

Front

Right Left

Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///

Pins And Needles

≡ ≡ ≡

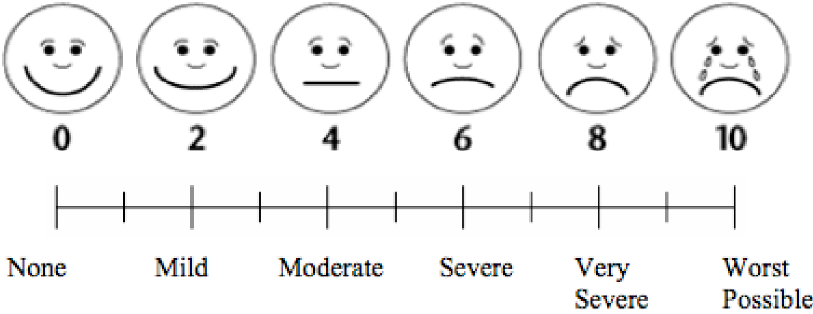
Back

Left Right

Please indicate the percent of pain that you feel in your neck and arms:

Neck Pain		%
Arm Pain		%
Total	100	%

4. Please place an X on the hash mark that most accurately describes your pain now:



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5. How did the pain begin? ☐ *Unknown* ☐ *Auto accident* ☐ *On the job injury*

☐ ____

____

6. What makes the pain worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Nothing ☐ ______________

7. What makes the pain better?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Nothing ☐ ______________

8. Where do you feel weakness?

☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg ☐ No weakness

9. Where has there been a recent CHANGE?

☐ Walking ability ☐ Balance ☐ Writing ability ☐ Ability to button shirt/pants

☐ Controlling urine or stool ☐ No changes

10. How far can you walk?

☐ < 100 yards ☐ 100 - 500 yards ☐ 500 - 1000 yards ☐ > 1000 yards

11. What treatments have you tried for this problem? (Check all that apply)

☐ Nothing ☐ Acupuncture ☐ Chiropractic Care ☐ Rest

☐ Formal Physical Therapy - How many sessions:______________________________

☐ Medications: ☐ Tylenol ☐ Anti-inflammatories (Aleve, Motrin, Advil, etc.)

☐ Muscle relaxants ☐ Pain medications:______________________________

____

☐ Transforaminal epidural steroid injection ☐ Epidural steroid injection ☐ Facet joint injection

12. Please list all Care Givers that have treated you for this condition:

☐ ____

13. Which of the following are involved with your current pain/injury: (Check all that apply)

☐ Workers compensation ☐ Personal lawsuit ☐ Disability claim ☐ Social security claim

14. How were you referred to our practice?

☐ Doctor:______________________ ☐ Emergency Department

☐ Other:____

15. *Is there anything else that you think we should know about?*______________________________

____

____

____

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Past Medical History

☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ Diabetes
☐ Congestive heart failure ☐ Emphysema/COPD ☐ Asthma ☐ Blood clot/DVT/PE
☐ Fibromyalgia ☐ Migraine headaches ☐ Gout ☐ Kidney disease
☐ Bleeding disorder ☐ Low/high thyroid ☐ GERD/ulcers ☐ Liver disease
☐ Osteoporosis ☐ Stroke ☐ Hepatitis ☐ None
☐ Cancer(type:_______________________________________)
☐ Other:____

____

Past Surgical History

Surgical Procedure	Date	Complication

Medications

Medication	Dose	Frequency
Example: Motrin	600 mg	Three times a day

Allergies ☐ No known drug allergies ☐ ______________________________________

Social History Occupation:____

Are you currently working? ☐ Yes ☐ No If yes, how many hours per week?____________
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have any children? ☐ Yes ☐ No If yes, how many?_______________________
Do you live alone? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?____________
Do you chew tobacco? ☐ Yes ☐ No
Any illicit drugs? ☐ Yes ☐ No
Do you drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ Rarely ☐ Never

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Family History

Do you have a family history of:

Diabetes?	☐ Yes	☐ No	DVT or PE (pulmonary embolus)?	☐ Yes	☐ No
Heart disease?	☐ Yes	☐ No	Malignant hyperthermia?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No	Mental health disorders?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No	What type of cancer?______________________		

Review of Systems

Do you have any current (within the last few weeks) problems with:

Constitutional symptoms

Good general health	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Unexplained weight change	☐ Yes	☐ No

Eyes

Wear glasses or contacts	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No

Ears, nose, mouth, throat

Change in hearing ability	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No

Cardiovascular

Chest pains	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Swelling of feet or ankles	☐ Yes	☐ No
Sudden heartbeat changes	☐ Yes	☐ No

Respiratory

Shortness of breath	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

Gastrointestinal

Nausea or vomiting	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No
Females only:		
Painful periods	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No

Date of last menstrual period ___________

Musculoskeletal

Joint pain	☐ Yes	☐ No
Joint stiffness or swelling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Difficulty walking	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No

Integumentary

Rash or itching	☐ Yes	☐ No
Change in skin, hair or nails	☐ Yes	☐ No
Females only:		
Breast pain or lumps	☐ Yes	☐ No

Neurological

Frequent headaches	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No

Endocrine

Heat or cold intolerance	☐ Yes	☐ No
Change in hat or glove size	☐ Yes	☐ No
Excessive thirst or urination	☐ Yes	☐ No

Hematologic/lymphatic

Easily bruise or bleed	☐ Yes	☐ No
Slow to heal after cuts	☐ Yes	☐ No
Swollen glands	☐ Yes	☐ No

Allergic/immunologic

Hay fever	☐ Yes	☐ No
Recurrent infections	☐ Yes	☐ No

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Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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
- ☐ 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 difficulty and stay in bed.

SECTION 3 - LIFTING
- ☐ I can lift heavy weight 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, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can mange 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 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 that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that 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 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 can't 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 cant drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs 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 recreation activities, with some neck pain at all.
- ☐ 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 few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

I attest that the above answers are true and have been completed to the best of my knowledge.

Patient Signature:____ **Date/Time:**______________________

I have reviewed the history and review of systems.

Physician Signature:______________________________________ Date/Time:______________________

Mild disability 10-28%, Moderate disability 30-48%, Severe disability 50-68%, Complete >70%   NDI Score:____________