

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient Neck/Arm Form**

**Please complete all questions. All responses will remain confidential.**

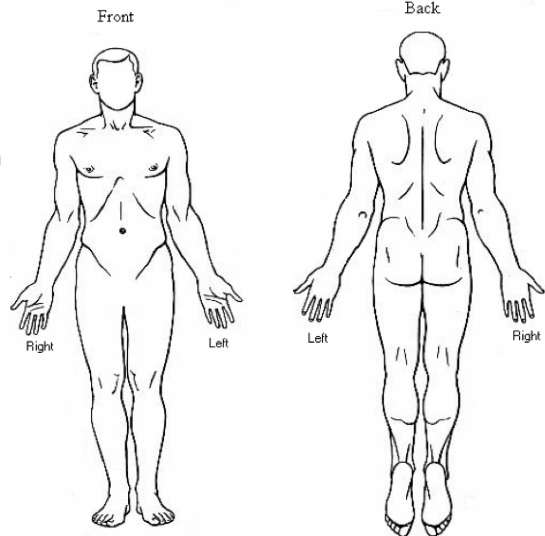
1. Please mark where your pain is on the diagram below:

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

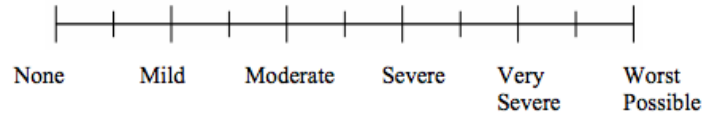
Neck Pain		%
Arm Pain		%
Total	100	%

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
- ≡ ≡ ≡



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



3. How long have you had this pain? \_\_\_\_\_

4. How did this pain begin?

- Auto accident     On the job     Unknown     \_\_\_\_\_

5. What makes the pain worse?

- Sitting     Standing     Walking     Lying down     Nothing     \_\_\_\_\_

6. What makes the pain better?

- Sitting     Standing     Walking     Lying down     Nothing     \_\_\_\_\_

7. How far can you walk?

- < 100 yards     > 100 yards

8. Please check all assistive devices that you use:

- Walker     Cane     Wheelchair

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

- Acupuncture     Chiropractic Care     Physical Therapy - # sessions \_\_\_\_\_
- Tylenol     Anti-inflammatories (Aleve, Motrin, Advil, etc.)     Muscle relaxants
- Pain medications (please list): \_\_\_\_\_

- Transforaminal epidural steroid injection     Epidural steroid injection     Facet joint injection

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

- Workers compensation     Personal lawsuit     Disability claim     Social security claim

11. Is there anything else that you think we should know about? \_\_\_\_\_

**Medical History**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Emphysema/COPD     | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Blood clot/DVT/PE |
| <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Gout               | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Low thyroid        | <input type="checkbox"/> Reflux/ulcers      | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Cancer(type:_____) |  |
| <input type="checkbox"/> Other:_____              |   |   |  |

**Surgical History**

Surgical Procedure	Date	Complication

**Medications**

Medication	Dose	Frequency

**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

**Family History**

Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	DVT or PE (pulmonary embolus)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant hyperthermia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental health disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained weight change	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Eyes*

Wear glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Ears, nose, mouth, throat*

Nose bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swallowing difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Cardiovascular*

Chest pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of feet or ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sudden heartbeat changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Respiratory*

Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Gastrointestinal*

Nausea or vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in bowel movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Genitourinary*

Frequent urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning or painful urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Females only:

Painful periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last menstrual period	_____	

*Musculoskeletal*

Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint stiffness or swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle pain or cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Integumentary*

Rash or itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in skin, hair or nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Females only:

Breast pain or lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*Neurological*

Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Psychiatric*

Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Endocrine*

Heat or cold intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive thirst or urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Hematologic/lymphatic*

Easily bruise or bleed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Slow to heal after cuts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Allergic/immunologic*

Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**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 manage 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:** \_\_\_\_\_

Min disability 0-18%, Mod 20-38%, Severe 40-58%, Crippling 60-78%, Exaggerated 80-100% ODI Score: \_\_\_\_\_