

CERVICAL

PERSONAL INFORMATION

(Please Print or Type)

Patient Name: _____
Last First M.I.

Registration Date: ____/____/____ Birthdate: ____/____/____ Age: _____

Social Security #: _____ - _____ - _____ Sex: _____

Address: _____ Apt. # _____
Street

City State Zip

Telephone Numbers: (_____) _____ (_____) _____
Home Phone Work Phone

Occupation: _____

Employer: _____
Name

Street Phone Number

City State Zip

Dates of Injury/Onset: First Injury/Onset: ____/____/____
Second Injury: ____/____/____
Third Injury: ____/____/____
Fourth Injury: ____/____/____

Referring Source: _____
Name

Street Phone Number

City State Zip

Referring Source is: 1) Physician 2) Chiropractor 3) Other Healthcare Professional
4) Another Patient 5) Workers Comp 6) Friend
7) Yellow Pages 8) Other _____

Family Physician: _____

Emergency Contact: *(A person not living at your residence)*

Name: _____ City: _____ State: _____

Work Phone: (_____) _____ Home: (_____) _____

Spouse Information:

Name: _____
Last First M.I.

Birthdate: ____/____/____ Social Security Number: _____ - _____ - _____

Employer: _____ Work Phone: (_____) _____

Attorney: *(Complete only if an attorney is representing you for this injury)*

Name

Street Phone Number

City State Zip

Do you want a copy of this report sent to your attorney? **(Circle One)** YES NO

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INSURANCE INFORMATION

PRIMARY INSURANCE :

_____ (_____) _____
Insurance Company Phone Number

_____ Suite _____
Street

_____ State _____ Zip _____
City

Group #: _____ Policy or ID #: _____

Subscriber's Name: _____

RELATIONSHIP: (**Circle One**) Self Spouse Mother Father

SECONDARY INSURANCE :

_____ (_____) _____
Insurance Company Phone Number

_____ Suite _____
Street

_____ State _____ Zip _____
City

Group #: _____ Policy or ID #: _____

Subscriber's Name: _____

RELATIONSHIP: (**Circle One**) Spouse Mother Father Self

WORKER'S COMPENSATION :

_____ (_____) _____
Insurance Company Phone Number

_____ Suite _____
Street

_____ State _____ Zip _____
City

File or Claim #: _____ Case Manager: _____

Employer at the Time of Injury :

_____ (_____) _____
Company Phone Number

_____ Suite _____
Street

_____ State _____ Zip _____
City

PAIN DRAWING

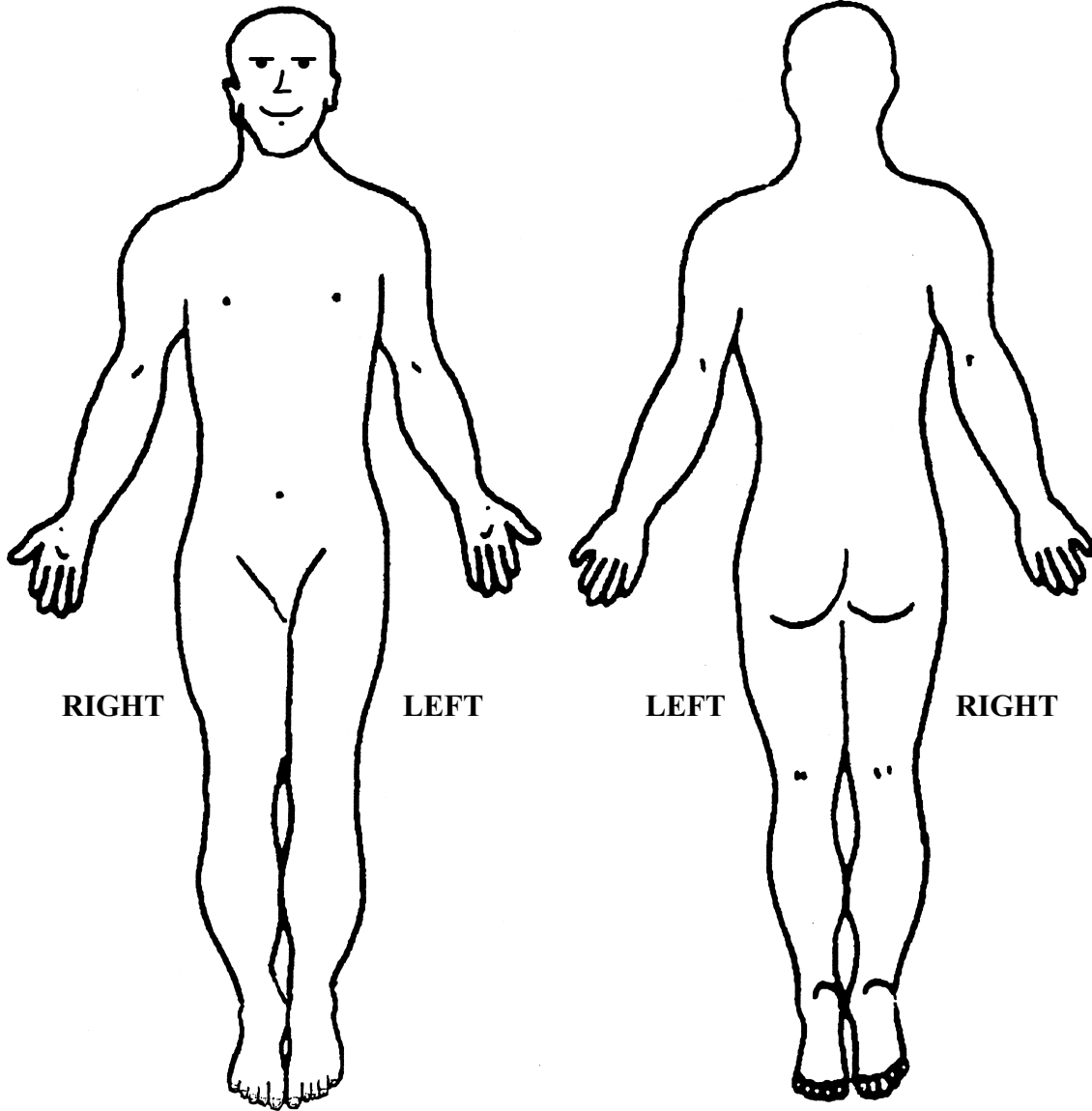
Patient: _____

Date: _____

DRAW the location of your pain on the body outlines below.

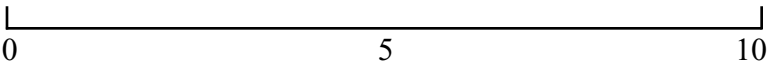
FRONT VIEW

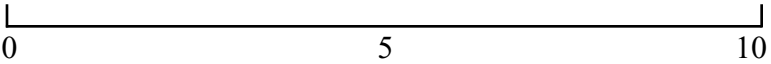
BACK VIEW

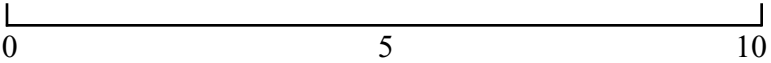


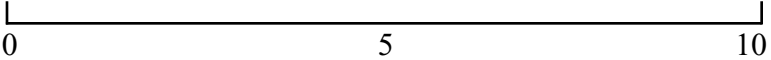
The lines below are diagrammatic representations of your pain level. On a 0 to 10 scale (0 being no pain and 10, being the worst possible pain) please place a vertical mark on each line below to indicate your pain level:

Example: 

Today: 

Most days: 

The worst it gets: 

The least it gets: 

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10. Circle **ANY** and **ALL** areas of weakness (Right, Midline, and/or Left):

- | | | | | |
|--------------|---|-------|---------|------|
| NECK | - | Right | Midline | Left |
| SHOULDERS(s) | - | Right | | Left |
| ARMS | - | Right | | Left |
| HANDS | - | Right | | Left |
| HIPS | - | Right | | Left |
| LEGS/FEET | - | Right | | Left |

11. Please rate your pain over recent weeks using the following scale:

- 1 = no pain
- 2 = mild pain
- 3 = moderate requiring mild pain medications such as Tylenol or aspirin
- 4 = severe causing you to markedly modify your activities and/or take strong medications such as codeine or other narcotics and prescription drugs
- 5 = so intense you can barely function
- 6 = so excruciating that it is unbearable

1.	At its worst	1	2	3	4	5	6
2.	Most of the time (usual)	1	2	3	4	5	6
3.	At its best (least)	1	2	3	4	5	6
4.	In the morning:						
	a) before getting out of bed	1	2	3	4	5	6
	b) after getting out of bed	1	2	3	4	5	6
5.	Midday	1	2	3	4	5	6
6.	Evening	1	2	3	4	5	6
7.	Night time	1	2	3	4	5	6

12. Which of the following activities **CHANGES** your pain? (*checkmark (✓) all that apply*):

	Aggravates Pain	Relieves Pain
1. Turning head	_____	_____
2. Looking down	_____	_____
3. Looking up	_____	_____
4. Lifting	_____	_____
5. Driving	_____	_____
6. Standing	_____	_____
7. Walking	_____	_____
8. Lying on your side	_____	_____
9. Lying on your back	_____	_____
10. Lying on your stomach	_____	_____
11. Coughing/Sneezing	_____	_____

Now go back and put an asterisk (*) next to the most aggravating and the most relieving activity.

13. Please estimate how many hours you spend from 7:00 a.m. to 11:00 p.m. each day performing the following activities:

1. Working	_____	5. Sitting	_____
2. Driving	_____	6. On couch/recliner	_____
3. Housekeeping	_____	7. In bed	_____
4. Walking	_____	8. Other major activity	_____

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PAST CERVICAL HISTORY

14. Which of the following treatments have you tried? Please place a checkmark (✓) to indicate the effect of those which have been used in an attempt to heal your present injury. (Do **NOT** mark those not tried):

	Not Helpful	Helpful	For How Long?
1. Physical Therapy	_____	_____	_____
2. Epidural Block/Injections	_____	_____	_____
3. Facet Block/Injection	_____	_____	_____
4. Exercises	_____	_____	_____
5. Traction	_____	_____	_____
6. Hot Packs	_____	_____	_____
7. Ice Packs	_____	_____	_____
8. TENS Unit	_____	_____	_____
9. Ultrasound	_____	_____	_____
10. Neck School	_____	_____	_____
11. Chiropractor	_____	_____	_____
12. Acupuncture	_____	_____	_____
13. Other: _____	_____	_____	_____

15. Please indicate with a checkmark (✓) if you have had any of the following studies.

Also, please indicate the Month & Year, if known:

1. Plain X-ray of neck	_____	4. Myelogram	_____
2. CT scan	_____	5. Discogram	_____
3. MRI	_____	6. EMG	_____

16. You have already given us the necessary information about your present pain; now please give the following information about any other previous episodes of neck problems.

1. Approximate dates: Episode A: ___/___/___
 Episode B: ___/___/___
 Episode C: ___/___/___
 Episode D: ___/___/___

2. Using the following chart, please **CIRCLE** the number(s) that indicate(s) where the symptoms of these other injuries were located:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Unknown	=	1	1	1	1
Base of Skull	=	2	2	2	2
Neck	=	3	3	3	3
Shoulders	=	4	4	4	4
Arms	=	5	5	5	5
Hands	=	6	6	6	6
Lower Extremities	=	7	7	7	7

3. Using the following chart, please **CIRCLE** the number that indicates how long the symptoms of your other injuries lasted:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Less than one month	=	1	1	1	1
1 to 3 months	=	2	2	2	2
3 to 6 months	=	3	3	3	3
6 months to one year	=	4	4	4	4
More than one year	=	5	5	5	5

4. Using the following chart, please **CIRCLE** the number that indicates the severity of your pain at the time of these other injuries:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Mild pain	=	1	1	1	1
Moderate pain	=	2	2	2	2
Severe pain	=	3	3	3	3

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CERVICAL SPINE SURGERY HISTORY

17. Have you had cervical (neck) surgery in the past? (**CIRCLE ONE**) **YES** **NO**

If you answered “**YES**” to the above question, please complete the following:

a. Give the details of all your neck surgeries:

	<u>Date</u>	<u>Doctor</u>	<u>Hospital</u>	<u>City/State</u>
1st:	___/___/___	_____	_____	_____
2nd:	___/___/___	_____	_____	_____
3rd:	___/___/___	_____	_____	_____
4th:	___/___/___	_____	_____	_____

b. Please use the list below to indicate what was done in each procedure. Use all that apply.

- 1 = Unkown
- 2 = Laminectomy (also known as a “decompression”) (Scar will be on back of neck)
- 3 = Disc removal from the Front (scar on front of neck)
- 4 = Disc removal from the Back (scar on back of neck)
- 5 = Fusion
- 6 = Placing or inserting screws, rods, cages, or other metal or synthetic devices
- 7 = Using bone graft from your body
- 8 = Using bone graft from a cadaver or bone bank
- 9 = Removing metal or other devices

1st surgery: = _____

2nd surgery: = _____

3rd surgery: = _____

4th surgery: = _____

c. Did you improve from your surgical procedure(s)?

1st Surgery: **YES** **NO**

2nd Surgery: **YES** **NO**

3rd Surgery: **YES** **NO**

4th Surgery: **YES** **NO**

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MEDICAL, SOCIAL & VOCATIONAL HISTORY

MEDICATIONS

18. What medications do you take at the present time?

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Now go back and put an asterisk (*) next to those medications which help relieve your pain.

19. List **ALL** allergies **and** the reactions they cause (e.g. "Sulfa drugs cause a rash"): _____

MEDICAL/SURGICAL HISTORY

20. Have you been treated for any of the following? (Place a checkmark (✓) on **ALL** that apply):

- | | |
|---------------------------|--------------------------------|
| _____ High Blood Pressure | _____ Urinary Tract Infection |
| _____ Angina | _____ Bleeding Disorders |
| _____ Heart Attack | _____ Blood Transfusions |
| _____ Asthma | _____ Blood Clots in the legs |
| _____ Bronchitis | _____ Blood Clots in the lungs |
| _____ Pneumonia | _____ Hepatitis |
| _____ Diabetes | _____ AIDS or HIV |
| | _____ Stroke |

21. List **ALL** other major illnesses not mentioned above that have been treated in the past 5 years:

22. List **ALL** previous surgeries, (*excluding the surgeries already detailed*):

23. Are you currently under a doctor's care for **ANY** medical condition? (**Circle One**) **YES** **NO**

24. List all other physicians with whom have consulted in the past 5 years:

Now go back and put an asterisk (*) next to physicians you have seen in the past 6 months.

FAMILY HISTORY

25. Has anyone in your family ever had any of the following conditions? (**Circle ALL that apply**)

- | | | | |
|------------------|-------------------|-------------------|------------------------|
| 1 = Arthritis | 2 = Back pain | 3 = Neck pain | 4 = Migraine headaches |
| 5 = Tuberculosis | 6 = Heart trouble | 7 = Cancer: Kind? | _____ |

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SOCIAL HISTORY

26. Are you: (Circle One) Single Married Divorced Separated Widowed

27. Number of children and ages, if any: _____

28. Are you: (Circle One)

1 = Unemployed 2 = Employed 3 = Student 4 = Retired

If you answered "1" or "2" please answer the following questions:

A. How long have you been off work this year?

- 1 = No Time 4 = 1 to 2 months
2 = About 1 week 5 = About 2 to 6 months
3 = 2 to 4 weeks 6 = About 6 months to one year

B. Are you presently working? (CIRCLE ONE) YES NO

C. If you answered "no", please complete the following:

- 1. What was the last date worked? ____ / ____ / ____
2. Is your job still available? YES NO
3. Was your reason for leaving work:
a = Due to circumstances related to this problem
b = Due to circumstances NOT related to this problem

29. Current source of income: (CIRCLE ALL that apply)

- 1 = Spouse 5 = Unemployment
2 = Employer 6 = Workers Compensation
3 = Social Security 7 = Family (other than spouse)
4 = Disability 8 = Other funds

30. Is your income sufficient to meet your needs? (CIRCLE ONE) YES NO

31. Are you a cigarette/cigar smoker? (CIRCLE ONE) YES NO

If you answered "YES", how much do you smoke per day?

- 1 = Less than 1/4 pack per day 5 = 1 pack per day
2 = 1/4 pack per day (5 cigarettes) 6 = 2 packs per day
3 = 1/2 pack per day (10 cigarettes) 7 = More than 2 packs per day
4 = 3/4 pack per day (15 cigarettes) 8 = Other: _____

32. Do you drink alcoholic beverages? (CIRCLE ONE) YES NO

If you answered "yes", please circle your average consumption?

- 1 = Less than 4 drinks per month 4 = 1 to 2 drinks per day
2 = 1 to 3 drinks per week 5 = 3 to 5 drinks per day
3 = 3 to 6 drinks per week 6 = More than 5 drinks per day

33. Have you used any "Street Drugs" in the last year? (CIRCLE ONE) YES NO

If you answered "YES", what drug(s) and how often? _____

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REVIEW OF SYSTEMS

34. Please **CIRCLE** any of the following problems which you now have or which you have had in the past 6 months:

General:

- 1 = Weight gain
- 2 = Weight loss
- 3 = Appetite change
- 4 = Marked fatigue
- 5 = Unexplained night fever
- 6 = Night sweats
- 7 = Difficulty sleeping
- 8 = Psychological difficulties

Joints:

- 1 = Pain
- 2 = Stiffness
- 3 = Redness
- 4 = Swelling

Lungs:

- 1 = Chest pain
- 2 = Recurring cough
- 3 = Wheezing

Cardiovascular:

- 1 = Chest pain, tightness
- 2 = Palpitations
- 3 = Shortness of breath with normal activities

Gastrointestinal:

- 1 = Uncontrolled loss of stool
- 2 = Persistent/recurring belly pain
- 3 = Diarrhea
- 4 = Blood in stool
- 5 = Heartburn
- 6 = Constipation
- 7 = Yellow jaundice
- 8 = Pain with bowel movement

Urological:

- 1 = Difficulty with urination
- 2 = Unable to control urine
- 3 = Pain with urination

Patient: _____

Date: _____

Oswestry Pain Questionnaire

This questionnaire has been designed to give your physician information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section **ONLY ONE BOX** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark one box which *most closely* describes your problem.

Section 1 - Pain Intensity

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

Section 2 - Personal Care (Washing, Dressing, etc)

- 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, wash with difficulty and stay in bed

Section 3 - Lifting

- I can lift heavy weights 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, e.g. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4 - Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/2 mile
- Pain prevents me from walking more than 1/4 mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6 - Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 1/2 hour
- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Section 7 - Sleeping

- Pain does not prevent me from sleeping
- I can sleep well only by using tablets
- Even when I take tablets I have less than six hours sleep
- Even when I take tablets I have less than four hours sleep
- Even when I take tablets I have less than two hours sleep
- Pain prevents me from sleeping at all

Section 8 - Sex Life

- My sex life is normal and causes no extra pain
- My sex life is normal but cause some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 - Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10 - Traveling

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

Number of Points: _____

Total Possible: _____

Score: _____ %