New Patient Questionnaire
Cervical Spine

Please answer all questions completely
Patient Name: 

Referring doctor name and address: 

If you were not referred by a physician, how did you find our office? 

Primary care doctor name and address: 

1. Your age: _______ Years  Gender: □ Male  □ Female
2. Symptoms: □ Neck pain □ Arm pain □ Numbness □ Weakness □ Poor balance □ Other 
3. How long have you had your symptoms? 
4. What caused your symptoms? □ Unknown □ Injury □ Other 
5. Have your symptoms improved or worsened recently? □ Improved  □ Worsened 
6. When did and what caused your symptoms improve or worsen? 

What % of your symptoms is in the NECK and ARM? (please check one box) 

- □ Neck 0%, Arm 100% 
- □ Neck 10%, Arm 90% 
- □ Neck 25%, Arm 75% 
- □ Neck 50%, Arm 50% 
- □ Neck 75%, Arm 25% 
- □ Neck 90%, Arm 10% 
- □ Neck 100%, Arm 0%

What % of your symptoms is in each ARM? (please check one box) 

- □ No ARM symptoms 
- □ Right 0%, Left 100% 
- □ Right 10%, Left 90% 
- □ Right 25%, Left 75% 
- □ Right 50%, Left 50% 
- □ Right 75%, Left 25% 
- □ Right 90%, Left 10% 
- □ Right 100%, Left 0%

Where in your ARM do you have PAIN or TINGLING? 

- □ Right  None 
- □ Right  Upper back 
- □ Right  Shoulder 
- □ Right  Upper arm 
- □ Right  Forearm 
- □ Right  Hand 
- □ Left  None 
- □ Left  Upper back 
- □ Left  Shoulder 
- □ Left  Upper arm 
- □ Left  Forearm 
- □ Left  Hand 

Where in your ARM do you have NUMBNESS 

- □ Right  None 
- □ Right  Upper arm 
- □ Right  Forearm 
- □ Right  Thumb 
- □ Right  Index finger 
- □ Right  Ring/small 
- □ Left  None 
- □ Left  Upper arm 
- □ Left  Forearm 
- □ Left  Thumb 
- □ Left  Index finger 
- □ Left  Ring/small

Where in your ARM do you have WEAKNESS 

- □ Right  None 
- □ Right  Shoulder 
- □ Right  Arm 
- □ Right  Forearm 
- □ Right  Hands 
- □ Left  None 
- □ Left  Shoulder 
- □ Left  Arm 
- □ Left  Forearm 
- □ Left  Hands
MY NECK PAIN IS (circle number)

0  1  2  3  4  5  6  7  8  9  10

No Pain  Slight  Mild  Moderate  Severe  Excruciating  Pain as bad as it could be

MY ARM PAIN IS (circle number)

0  1  2  3  4  5  6  7  8  9  10

No Pain  Slight  Mild  Moderate  Severe  Excruciating  Pain as bad as it could be

MY HEADACHE PAIN IS (circle number)

0  1  2  3  4  5  6  7  8  9  10

Please mark the areas on the diagram where you are having symptoms and the location where the symptoms radiate.

Please use the following symbols to indicate the type of symptoms and the location of the symptoms:

Pain= ------------------------------
Pins and Needles= 00000000
Numbness= XXXXXXXXXXX
7. How does your pain travel: □ Stays in my NECK □ Starts in the NECK and goes down the ARM
8. Raising my arm: □ Improves the pain □ Worsens the pain □ Does not affect the pain
9. Moving my neck: □ Improves the pain □ Worsens the pain □ Does not affect the pain
10. Do your hands feel clumsy? □ Yes □ No
11. Do you have a problem with balance or tripping? □ Yes □ No
12. Do you have headaches in the back of your head? □ Yes □ No
13. Does coughing or sneezing increase your symptoms? □ Yes □ No
14. Do you have difficulty with bowel or bladder control? □ No □ Yes; since____________
15. Have you missed work because of your symptoms? □ No □ Yes; how much time ______
16. Previous treatments for my condition have included: (check any boxes that apply)
   □ Nothing (no medicines, therapy, manipulations, injections, or braces)
   □ Physical therapy: did it help relieve your symptoms?____________
   □ Chiropractic manipulation: did it help relieve your symptoms?____________
   □ Braces: did it help relieve your symptoms?____________
   □ Spine injections: How many injections have you had?____________
       For how long did the injections relieve your pain?____________
   □ Surgery
       How many surgeries have you had on your NECK?____________
       When was/were the surgery(ies) on your NECK?___________________________
       Did surgery relieve your symptoms?__________________________
   □ Other treatment:______________________________________
17. Previous doctors seen for your spine problem: □ None

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<thead>
<tr>
<th>Doctor</th>
<th>Specialty</th>
<th>City</th>
<th>Recommendations/Treatments</th>
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18. List pain medications and dose taken for your spine problem: □ None

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<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
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MEDICAL CONDITIONS THAT YOU HAVE OR HAD IN THE PAST: (check all that apply)

- None apply
- Heart attack
- Heart failure
- High blood pressure
- Osteoarthritis
- Rheumatoid arthritis
- Ankylosing spondylitis
- Gout
- Osteoporosis
- Cancer (type)
- Serious injuries (explain)
- Other (explain)

MEDICATIONS YOU TAKE (please list):

- None

ARE YOU ALLERGIC TO MEDICINE? No known drug allergies

Medication

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<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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Are you allergic to latex? Yes

Have you had complications with anesthesia? Yes

PAST SURGICAL HISTORY

Please list previous surgeries, surgeon and date.

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<th>OPERATION</th>
<th>SURGEON</th>
<th>DATE</th>
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FAMILY HISTORY: (check all that apply)

- None apply
- Scoliosis
- Heart trouble
- Cancer
- Spine problems
- Stroke
- Arthritis
- High blood pressure
- Bleeding disorders
- Mental illness
- Blood clots
- Alcoholism
- Diabetes
- Seizures
- Bleeding disorders
- Tuberculosis
- Anemia
- Arthritis
- Other
SOCIAL HISTORY: (check all that apply)

1. Work status: □ Working: __Full time __ Part time □ Retired □ Disabled □ Unemployed
   Occupation: ___________________________________________

2. Marital status: □ Married □ Single □ Co-habitating □ Widowed □ Divorced

3. I live: □ Alone □ With:_______________________________

4. Number of living children:_____________

5. Tobacco and nicotine use: □ Never □ Cigar □ Chew □ Pipe
   □ Cigarettes ________ packs per day for ________ years.
   □ Quit – When? __________ after smoking ________ packs per day for ________ years

6. Alcohol intake: □ Never □ <2 drinks/month □ 1-2 drinks/week □ 1-2 drinks/day

7. Drug use: □ Never □ Currently □ In the past

8. If you have scoliosis how old were you when you started your menstrual cycle?__________

9. Because of my spine problem, I have filed or plan to file:
   □ A lawsuit □ A Worker’s Compensation claim □ Neither

REVIEW OF SYSTEMS: (check all that apply)
Constitutional □ None apply □ Recent weight change □ Poor appetite □ Hot or cold spells □ Fever or chills
Eyes □ None apply □ Change of vision □ Reading glasses
Cardiac □ None apply □ Abnormal heartbeat □ Heart or chest pain □ Swollen ankles
Respiratory □ None apply □ Shortness of breath □ Morning cough
Gastrointestinal □ None apply □ Frequent Constipation □ Frequent diarrhea □ Stomach pain □ Ulcers
   □ Nausea or vomiting
Genitourinary □ None apply □ Frequent urination □ Burning with urination □ Difficulty starting urination
Neurologic □ None apply □ Frequent headaches □ Blackouts □ Seizures □ Weakness
   □ Numbness
Skin □ None apply □ Frequent rash □ Acne
ENMT □ None apply □ Gum trouble □ Toothache □ Loss of hearing □ Cavities □ Missing teeth
   □ Dentures □ Ear pain/infection □ Nosebleeds □ Hoarseness
   □ Difficulty swallowing
Heme/Lymph □ None apply □ Anemia □ Blood clots □ Easily bruising □ Bleeding disorder
Psychiatric □ None apply □ Depression □ Schizophrenia □ Bipolar disorder □ Alcoholism
   □ Drug abuse

Patient Signature ____________________________ Date ____________________

Physician Signature __________________________ Date ____________________
Physical Examination (FOR OFFICE USE ONLY – Patients continue to the next page)

1. Constitutional:
   a. Vital Signs: Height ________ Weight _______ Pulse _______ Resp _______
   b. Appearance: Nutrition ______ Habitus _______ Deformity ______ Grooming _______

2. Neurological
   a. Orientation (PERSON/PLACE/TIME)   Mood/ Affect (depression, anxiety, agitation)

3. SKIN (scars, ulcerations, etc; location); Neck ______ Back _______ BUE _______ BLE _______

4. Adams forward bend: PT___________ MT___________ TL/L___________

5. Pain Range of Motion Cervical/Thoracic Spine (Yes/No)___________________________

6. Pain palpation Cervical/Thoracic Spine (Yes/No; Location)_________________________

7. GAIT: Tandem gait: (steady / unsteady); Able to Heel walk: (+ / - ); Able to Toe walk: (+ / - )

8. Motor:   Delt   Bi   Tri   WE   WF   FF   INT   Psoas   Quad   DF   EHL   PF   INV   EVER
           R
           L

9. Sensation: (symmetric, deficits, region of deficit):

10. DTR: Biceps   Triceps   BR   Knee   Ankles   Babinski   Hoffman’s   Clonus   Umbilicus
     R
     L

11. Cardiovascular:  DP   PT   Vascular changes   Swelling
     R
     L

Lab/EMG Results:
<table>
<thead>
<tr>
<th>Exam type</th>
<th>Date obtained</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight LEG raise</td>
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<tr>
<td>Femoral Stretch Test</td>
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<tr>
<td>Pain hip ROM</td>
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<td>Pain knee ROM</td>
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<td>Pain Shoulder ROM</td>
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<tr>
<td>Coordination</td>
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<tr>
<td>SI pain</td>
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<tr>
<td>Rhomberg</td>
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<tr>
<td>Carpal/Cubital tunnel exam</td>
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</tbody>
</table>

Diagnostic Imaging

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<tr>
<th>Exam type</th>
<th>Date obtained</th>
<th>Findings</th>
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</thead>
</table>

Assessment

Recommendations: Prescription Drug (mod-mgmt) Physical Therapy (low-mgmt) Injections (high DxP) Surgery (high)
mJOA Questionnaire

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

I. Arms
☐ Impossible to write
☐ Unreadable handwriting
☐ Writing only in capitals
☐ Disfigured handwriting
☐ None – No difficulties performing the above task(s)

II. Legs
☐ Unable to walk
☐ Can walk on flat floor with walking aid
☐ Can walk up or down stairs with handrail
☐ Lack of stability and smooth gait
☐ None – No difficulties performing the above task(s)

III. Sensation
☐ Upper extremity, severe sensory loss or pain
☐ Upper extremity, mild sensory loss
☐ Upper extremity, None – No difficulties performing the above task(s)

☐ Lower extremity, severe sensory loss or pain
☐ Lower extremity, mild sensory loss
☐ Lower extremity, None – No difficulties performing the above task(s)

☐ Trunk, severe sensory loss or pain
☐ Trunk, mild sensory loss
☐ Trunk, None – No difficulties performing the above task(s)

IV. Bladder function
☐ Unable to void – Complete retention
☐ Marked difficulty in urination – Inadequate evacuation, straining, dribbling of urine
☐ Difficulty in urination – Urinate frequently, hesitation in urination
☐ None – No difficulties performing the above task

___________________________
Patient Signature

___________________________
Date
Neck Disability Index

Please read: This questionnaire has been designed to give the doctor information as to how your neck 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 related 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 very severe at the moment
☐ The pain is the worst imaginable at the moment

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, I 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 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 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 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 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 pain in my neck
☐ I can drive my car as long as I want with moderate pain in my neck
☐ I cannot drive my car as long as I want because of moderate pain in my neck
☐ I cannot drive my car at all

Section 9 – Sleeping
☐ I have no problem 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 (3-6 hours sleepless)
☐ My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation
☐ I am able to engage in all my recreational activities with no neck pain at all
☐ I am able to engage in all my recreational activities with some pain in my neck
☐ I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
☐ I am able to engage in few of my usual recreational activities because of pain in my neck
☐ I can hardly do any recreational activities because of pain in my neck
☐ I cannot do any recreational activities at all

Patient Signature
Date
CURRENT SYMPTOMS

1. Please indicate those areas that have bothered you or limited your function in the past week.
   (Mark all that apply)
   - Shoulder
   - Arm above the elbow
   - Elbow
   - Arm below the elbow
   - Wrist/hand
   - Head
   - Neck
   - Upper back
   - Middle back
   - Lower back
   - Hip
   - Leg above the knee
   - Knee
   - Leg below the knee
   - Ankle/foot
   - Buttocks

In the past week, how often have you suffered:

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<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good bit of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
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<tbody>
<tr>
<td>2. Neck pain?</td>
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<td>3. Arm pain?</td>
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<td>4. Numbness or tingling in arm and/or hand?</td>
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<td>5. Weakness in arm and/or hand?</td>
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<td>6. Low back and/or buttocks pain?</td>
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<td>7. Leg pain?</td>
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<td>8. Numbness or tingling in leg and/or foot?</td>
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<td>9. Weakness in leg and/or foot?</td>
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In the past week, how bothersome have these symptoms been?

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<th></th>
<th>Not at all bothersome</th>
<th>Slightly bothersome</th>
<th>Somewhat bothersome</th>
<th>Moderately bothersome</th>
<th>Very bothersome</th>
<th>Extremely bothersome</th>
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<td>10. Neck pain?</td>
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<td>11. Arm pain?</td>
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<td>12. Numbness or tingling in arm and/or hand?</td>
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<td>14. Low back and/or buttocks pain?</td>
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<td>15. Leg pain?</td>
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<td>16. Numbness or tingling in leg and/or foot?</td>
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<td>17. Weakness in leg and/or foot?</td>
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18. Generally speaking, are your symptoms getting better or worse? (Fill in one circle)
   - Getting much better
   - Getting somewhat better
   - Getting somewhat worse
   - Getting much worse
   - Staying about the same

19. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? (Fill in one circle)
   - Very dissatisfied
   - Somewhat dissatisfied
   - Somewhat satisfied
   - Very satisfied
   - Neutral

_________________________  _________________________
Patient Signature           Date