Bone & Joint Specialists

CERVICAL

Name: _____ Age: _____ Date: _____

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just check the one which most closely describes your problem *right now.***

SECTION 1 - **Pain Intensify**

- ☐ A. I have no pain at the moment.
- ☐ B. The pain is mild at the moment.
- ☐ C. The pain comes and goes and is moderate.
- ☐ D. The pain is moderate and does not vary much.
- ☐ E. The pain is severe but comes and goes.
- ☐ F. The pain is severe and does not vary much.

SECTION 2 - **Personal Care (Washing, Dressing, etc.)**

- ☐ A. I can look after myself without causing extra pain.
- ☐ B. I can look after myself normally but it causes extra pain.
- ☐ C. It is painful to look after myself and I am slow and careful.
- ☐ D. I need some help, but manage most of my personal care.
- ☐ E. I need help every day in most aspects of self-care.
- ☐ F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - **Lifting**

- ☐ A. I can lift heavy weights without extra pain.
- ☐ B. I can lift heavy weights, but it causes extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- ☐ D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ E. I can lift very heavy weights.
- ☐ F. I cannot lift or carry anything at all .

SECTION 4 - **Reading**

- ☐ A. I can read as much as I want to with no pain in my neck.
- ☐ B. I can read as much as I want with slight pain in my neck.
- ☐ C. I can read as much as I want with moderate pain in my neck.
- ☐ D. I cannot read as much as I want because of moderate pain in my neck.
- ☐ E. I cannot read as much as I want because of severe pain in my neck.
- ☐ F. I cannot read at all.

SECTION 5 - **Headache**

- ☐ A. I have no headaches at all.
- ☐ B. I have slight headaches which come frequently.
- ☐ C. I have moderate headaches which come infrequently.
- ☐ D. I have moderate headaches which come frequently.
- ☐ E. I have severe headaches which come frequently.
- ☐ F. I have headaches almost all the time.

SECTION 6 - **Concentration**

- ☐ A. I can concentrate fully when I want to with no difficulty.
- ☐ B. I can concentrate fully when I want to with slight difficulty.
- ☐ C. I have a fair degree of difficulty in concentrating when I want to.
- ☐ D. I have a lot of difficulty in concentrating when I want to.
- ☐ E. I have a great deal of difficulty in concentrating when I want to.
- ☐ F. I cannot concentrate at all.

SECTION 7 - **Work**

- ☐ A. I can do as much work as I want to.
- ☐ B. I can only do my usual work, but no more.
- ☐ C. I can do most of my usual work, but no more.
- ☐ D. I cannot do my usual work.
- ☐ E. I can hardly do any work at all.
- ☐ F. I cannot do any work at all.

SECTION 8 - **Driving**

- ☐ A. I can drive my car without neck pain.
- ☐ B. I can drive my car as long as I want with slight pain in my neck.
- ☐ C. I can drive my car as long as I want with moderate pain in my neck.
- ☐ D. I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ E. I can hardly drive my car at all because of severe pain in my neck.
- ☐ F. I cannot drive my car at all.

SECTION 9 - **Sleeping**

- ☐ A. I have no trouble sleeping.
- ☐ B. My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ C. My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ D. My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ E. My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - **Recreation**

- ☐ A. I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ B. I am able to engage in all recreational activities with some pain in my neck.
- ☐ C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- ☐ D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ E. I can hardly do any recreational activities because of pain in my neck.
- ☐ F. I cannot do any recreational activities at all.

CERVICAL index score: _____

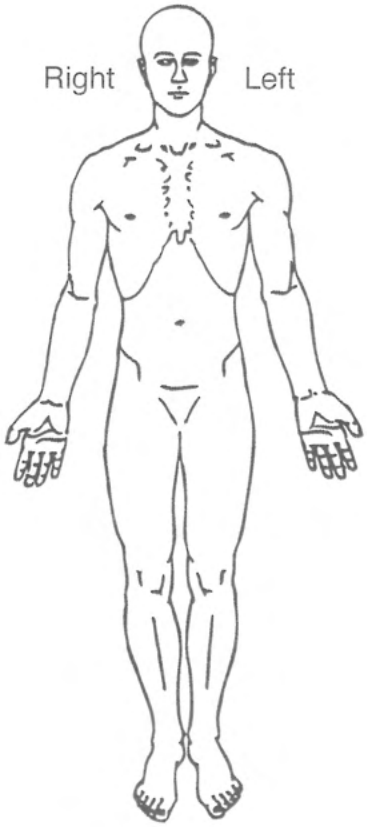
_____
Patient Signature

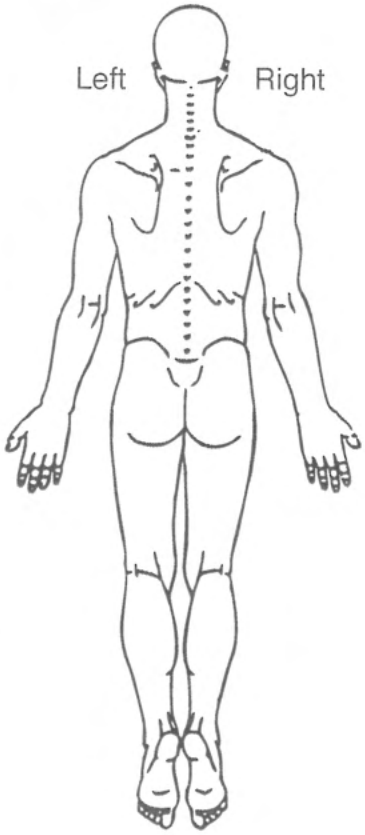
Bone & Joint Specialists

Patient Name: _____

Date: _____

Please mark an "X" on the body part(s) where you have pain.
Mark an "O" on the body parts where you have numbness.





NECK

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

BACK

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

RIGHT ARM

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

RIGHT LEG

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

LEFT ARM

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

LEFT LEG

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		Worst Pain Possible

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REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?
Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor.

H.E.E.N.T.

- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Hard of Hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Cough
- ☐ Other _____

PULMONARY

- ☐ Shortness of Breath
- ☐ Other _____

ABDOMINAL

- ☐ Abdominal Pain
- ☐ Other _____

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other _____

NEUROLOGIC

- ☐ Tremors
- ☐ Other _____

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Other _____

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Other _____

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Stress
- ☐ Poor Sleep
- ☐ Swelling of Feet
- ☐ Swollen Glands
- ☐ Problems with Blood Clots
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other _____

WORK STATUS

☐ Full Time ☐ Regular Duty

☐ Other _____

☐ Restrictions _____

Patient Name: _____

Date: _____

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications Currently Taking: Dosage Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Pharmacy:

Name: _____

Address: _____

Phone: _____

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PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Birthplace: _____

Reason you are being seen here: ☐ Pain ☐ Disability ☐ Medication

Other: _____

Have you been seen here within the past 3 years? ☐ Yes ☐ No

Hand Dominance: ☐ Left ☐ Right

PAST MEDICAL HISTORY: *(Please check any/all of the following that you have experienced.)*

- ☐ AIDS
- ☐ Anemia
- ☐ Anxiety Problem
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disease
- ☐ Cancer
- ☐ Colon Polyp
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Ear Trouble
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Fibromyalgia
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injury
- ☐ Heart Attack/Angina
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Polio
- ☐ Psychological/Psychiatric Problem
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Other Medical Problems: _____

Allergies: _____

Injuries: Please list all fractures, injuries, and motor vehicle accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury

Hospitalization/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery

Please continue on the other side

Have you ever had a blood transfusion? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you smoke now? ☐ Yes ☐ No _____ Packs per day

Did you smoke in the past? ☐ Yes ☐ No _____ Packs per day

Do you drink alcohol? ☐ Yes ☐ No _____ Drinks per week

Do you have a history of drug/alcohol abuse? ☐ Yes ☐ No

LEVEL OF EDUCATION:

☐ Grade School ☐ High School ☐ Graduate School ☐ Bachelor Degree ☐ Associate Degree

FAMILY HISTORY:

Please check the box of any/all of the following problems that your blood relatives (i.e. parents, brothers, sisters, grandparents, aunts, uncles, children) have had:

Illness	Relative/Family Member (i.e. Mom, Grandfather)
☐ Arthritis	
☐ Back or Neck Surgery	
☐ Back Pain/Sciatica	
☐ Cancer	
☐ Diabetes	
☐ Heart Attack/Heart Disease	
☐ High Blood Pressure	
☐ Mental Illness	
☐ Muscle Disease	
☐ Neck Pain	
☐ Nerve Disease	
☐ Stroke	

Relation	Age	State of Health	Medical Problems	Age At Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				

Patient Signature: _____

Bone & Joint Specialists

PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of years at this job: _____

Are you currently working? ☐ Yes ☐ No If yes: ☐ Part-time ☐ Full-time

☐ Regular Duty ☐ Modified Duty Working _____ Hours per week

What are your restrictions, if any? _____

_____

Does your job require you to: (please check all that apply)

☐ Lift or carry greater than 15 lbs. ☐ Bend or twist repetitively

☐ Work overhead ☐ Repetitive motion of the arms or legs

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date problem/symptoms started: _____

Location of symptoms/pain when the problem started: _____

HOW DID THE PROBLEM START?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall ☐ Other: _____

Please briefly describe: _____

Location of symptoms/pain now: _____

Frequency of symptoms/pain: (please check one) ☐ Constant ☐ Intermittent ☐ Rare

Since the onset of symptoms, has the problem: (please check one) ☐ Improved ☐ Worsened ☐ Stayed The Same

Does coughing or sneezing cause any pain? ☐ Yes ☐ No

If so, where? _____

Do any of the following activities make your symptoms worse? (please check all that apply)

☐ Walking ☐ Lying ☐ Bending/Twisting ☐ Working Overhead

☐ Sitting ☐ Kneeling ☐ Lifting/Carrying ☐ Other: _____

☐ Standing ☐ Typing ☐ Pushing/Pulling

List anything (i.e. activities, positions or treatments) that makes the pain better:

_____

Do you have any weakness, if so, which arm, leg or muscle? _____

Have you had any new or recurrent problems with: Control of urination? ☐ Yes ☐ No

Bowel movements? ☐ Yes ☐ No

Have you experienced recent weight loss or fevers? ☐ Yes ☐ No

Please continue on the other side

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

DIAGNOSTIC HISTORY:

TEST	RECEIVED	DATE OF TEST/LOCATION
X-ray	☐ Yes ☐ No	_____
MRI Scan	☐ Yes ☐ No	_____
CTScan	☐ Yes ☐ No	_____
Bone Scan	☐ Yes ☐ No	_____
EMG	☐ Yes ☐ No	_____
Other: _____	☐ Yes ☐ No	_____

MEDICATIONS *(If yes, please circle the medication below)*	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories	Naprosyn, Ibuprofen, Vioxx	☐ Yes ☐ No	☐ Yes ☐ No
Cox-2 Inhibitors	Voltaren, Celebrex, Bexlra	☐ Yes ☐ No	☐ Yes ☐ No
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	☐ Yes ☐ No	☐ Yes ☐ No
Pain Medication	Tylenol w/Codeine, Vicodin, Darvocet Percocet	☐ Yes ☐ No	☐ Yes ☐ No
Oral Steroid	Prednisone, Medrol Dose Pak	☐ Yes ☐ No	☐ Yes ☐ No
Neurontin, Zonegram, Paxil, Amitriplyline, Nortriptyline, Pamelor, Elavil, Prozac		☐ Yes ☐ No	☐ Yes ☐ No
Other: Please list: _____		☐ Yes ☐ No	☐ Yes ☐ No

TREATMENTS	RECEIVED	DID THIS HELP?
Physical Therapy/Exercise	☐ Yes ☐ No	☐ Yes ☐ No
Chiropractic Care	☐ Yes ☐ No	☐ Yes ☐ No
Injections in muscle or other injections in office	☐ Yes ☐ No	☐ Yes ☐ No
Epidural Steroid Injections	☐ Yes ☐ No	☐ Yes ☐ No
Facet Blocks	☐ Yes ☐ No	☐ Yes ☐ No
Braces/Corsets	☐ Yes ☐ No	☐ Yes ☐ No

Back Surgery: ☐ Cervical ☐ Thoracic ☐ Lumber When:_____

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine?

☐ Yes ☐ No If yes, please list:

PHYSICIAN NAME	MONTH/YEAR OF TREATMENT
_____	_____
_____	_____
_____	_____

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ☐ Yes ☐ No

If yes, please list your attorney's name:_____

Patient Signature: _____