

NECK/ CERVICAL SPINE PATIENT EVALUATION

NAME: _____

Onset: gradual sudden no injury injury **Date:** _____ **Work related?** no yes

Emergency Department? no yes _____

How, when, and what happened? _____

Have you had a similar problem in the past? If so, describe:

Severity: mild moderate severe incapacitating

Status: improved no change worse resolved

Frequency: constant intermittent daily weekly monthly

Location of Pain: no pain head (right/left/bilateral) scalp (right/left/bilateral)
 anterior neck (right/left/bilateral) posterior neck (right/left/bilateral) shoulder (right/left/bilateral)
 arm (right/left/bilateral) upper back (right/left/bilateral) scapula (right/left/bilateral)
 interscapular (right/left/bilateral) mid back (right/left/bilateral) chest (right/left/bilateral)
 flank (right/left/bilateral) Other: _____

Radiation of Pain?: none head (right/left/bilateral) scalp (right/left/bilateral)
 face (right/left/bilateral) upper arm (right/left/bilateral) elbow (right/left/bilateral)
 forearm (right/left/bilateral) interscapular (right/left/bilateral) wrist (right/left/bilateral)
 hand (right/left/bilateral) hand(right/left/bilateral) thumb (right/left/bilateral)
 index finger (right/left/bilateral) 5th finger (right/left/bilateral) Other: _____

Quality: aching burning discomforting dull gnawing lancinating piercing sharp
 shooting stabbing throbbing tingling Other: _____

Context/Injury: axial loading bending over blow from behind cervical compression
 driving off road hard fall hyperflexion injury lifting lying down
 motor vehicle accident motorcycle accident physical assault pulling sitting sports
 sudden movement twisting movement walking upstairs previous injury
 Other trauma details (type, where, when, date) _____

Aggravated by: nothing bending climbing stairs coughing defecation driving exertion
 flexion hyperextension kneeling lifting lying down prolonged sitting pushing rotation
 running sneezing standing stooping straining stress turning head twisting Valsalva
 walking working Other: _____

Relieved by: Nothing acupuncture cervical collar cervical traction cold compresses exercise
 heating pad ice injection lateral bending manipulation massage muscle relaxation
 narcotic medication (_____) NSAIDS (_____) OTC meds (_____) physical therapy
 rest rotation sitting splint standing stretching twisting walking other _____

Gait Aids: Not required Cane Crutches Single crutch Walker Wheelchair

Associated Symptoms: bladder dysfunction not spinal related bladder incontinence bladder retention
 bowel dysfunction not spinal related bowel incontinence bowel retention decreased mobility
 dermatomic rash difficulty sleeping disequilibrium dysphagia incoordination muscle atrophy
 muscle spasm numbness other joint pain rash sexual dysfunction
 sexual dysfunction not spinal related tenderness tingling weakness weight other _____

What has been done so far?

Surgery(type, doctor, and date): _____

X-rays and Date: _____

MRI and Date: _____

EMG and Date: _____

Other diagnostic testing and Date: _____

Injections: _____ Relief felt: None Minimal Moderate Significant

Physical Therapy: _____ Relief felt: None Minimal Moderate Significant

Brace (Describe): _____ Relief felt: None Minimal Moderate Significant

Medication taken for this problem: _____

Function:

What activities do your symptoms prevent you from doing?
