TUCSON ORTHOPAEDIC INSTITUTE

CERVICAL SPINE APPOINTMENT

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NAME _____

Please circle and/or fill in the answers to the following questions on all pages.

Who referred you to our office? _____

Who is your family physician? _____

Other physicians who should receive correspondence about today's visit? _____

Age _____ Gender_____ Occupation _____

Is this a **work related** injury? Yes No

Main Complaint: What is your main complaint?

_____ **Neck Pain**
_____ **Arm Pain** Right Left
_____ **Both Arms** Which arm is worse? Right Left

Have you had **previous cervical spine surgery?** Yes No

Duration of symptoms

How long have you had neck pain? _____
How long have you had arm pain? _____
Are the symptoms **episodic** or **constant**? **(Circle one)**
Since the onset of the current symptoms, you feel: Better Worse Same

Does the Arm Pain travel down your arm? Yes No

Arm Weakness? Yes No Which arm? Right Left

Description of pain (circle all that apply)

Arm pain Sharp Dull Aching Burning Stabbing Electrical

- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your arm pain at its:
  Worst _____Usually _____
- Does the arm pain wake you up at night? Yes No
- Arm symptoms worsen with: Athletic activity Driving Walking Standing Sitting Lying down
- Arm symptoms improve with: Athletic activity Driving Walking Standing Sitting Lying down
- Numbness and Tingling down the arm? Yes No
- Do you have difficulty with your handwriting? Yes No
- Do your hands feel clumsy? Yes No
- Do you have problems with your balance? Yes No
- Any recent falls because of poor balance? Yes No

Neck Pain (circle all that apply) Sharp Dull Aching Burning Stabbing Electrical

- Neck Pain: **constant** or **comes and goes**
- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your neck pain at its:
  Worst _____Usually _____
- Does your neck pain wake you up at night? Yes No
- Neck symptoms worsen with: Athletic activity Driving Walking Standing Sitting Lying down
- Neck symptoms are improved with: Lying down Sitting Walking Other _____

Exercise routine:_____days per week. What type of exercise?_____

Bladder problems:
Do you suffer from urinary incontinence? Yes No Date it started:_____

Treatment for this problem thus far:
What **Medications** are you **currently** taking for the pain? **What dose and how often?**
1. 3.
2. 4.

Have you ever had **Cervical Epidural Steroid Injections?** Yes No

Have you undergone any **Physical Therapy** for this condition? Yes No
Did physical therapy help? Yes No
When was your last session of Physical Therapy? _____(Date)

Have you used a **neck brace?** Yes No Did it help? Yes No
What **other treatments** have you had?
__Chiropractic __Acupuncture __Massage __TENS unit Other_____

SOCIAL HISTORY:
Do you smoke? No Yes_____ How many packs per day?
Do you drink alcohol? No Yes_____ How much per day?

Are you currently taking any blood thinning medications? Yes No
Blood thinner: _____

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.
1. 3.
2. 4.

ADDITIONAL INFORMATION:

Patient Signature_____ Date: _____

Provider Signature_____ Reviewed Date:_____