CERVICAL FORM:

Patient Name: _____ **Today's Date:** _____

Neck Pain? YES NO Notes: _____

– Into Shoulder? YES NO RIGHT LEFT

– Into Arm? YES NO RIGHT LEFT

– Into Forearm? YES NO RIGHT– A P L LEFT– A P L

– Into Fingers? YES NO RIGHT LEFT

Numbness / Tingling? YES NO Notes: _____

Is it constant? YES NO Notes: _____

How long? Weeks: _____ Months: _____ Years: _____ Worse in the Last: _____

Overall how long? Weeks: _____ Months: _____ Years: _____

Have you had any problem like this in the past? YES NO Notes: _____

Has it gotten worse over the years? YES NO Notes: _____

Is the pain: ❑ Burning ❑ Ache ❑ Sharp ❑ Dull ❑ Deep ❑ Throbbing _____

1 to 10 when pain is at its worst: 1 2 3 4 5 6 7 8 9 10

Did the pain come on: ❑ Gradually ❑ Suddenly _____

Injury: _____

Do you smoke? YES NO How Much? _____

What aggravates your pain?

❑ Bending Neck ❑ Turning Neck ❑ Sitting ❑ Standing ❑ Walking ❑ Driving

❑ Laying Down ❑ Reading ❑ Computer ❑ Other: _____

Do any of these relieve the pain?

❑ Heat ❑ Ice ❑ Stretching ❑ Pain Meds ❑ Rest

❑ Nothing ❑ Other: _____

Is it worse in the: ❑ Morning ❑ Afternoon ❑ Evening ❑ Night / Sleep ❑ Increase w / Activities ❑ All Same

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Have you been told exactly what condition(s) you have? _____

Have you tried:			**Did it:**		
Medications:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Physical Therapy:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Exercise / Stretching:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Chiropractic:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Epidurals:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Rhizotomy:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Surgery:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Other: _____	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief

Have you been told you need an epidural or surgery: YES NO By whom? _____

How do you feel about spinal surgery as a possibility? _____

Any other major health challenges? _____

Any recent...

- ❑ Recent spine fracture? YES NO Notes: _____
- ❑ Kidney infection? YES NO Notes: _____
- ❑ Urinary Tract infection? YES NO Notes: _____
- ❑ Bone Cancer? YES NO Notes: _____
- ❑ Bone infection / disease / disorder? YES NO Notes: _____
- ❑ Cramping? YES NO HANDS FINGERS
- ❑ Swelling? YES NO HANDS FINGERS

Any muscle weakness? YES NO Notes: _____

Any muscle atrophy? YES NO Notes: _____

How is this affecting your life? _____

How serious do you consider this? _____

What do you think will happen if left untreated? _____

Notes: _____