

NECK

REFERRED BY: Doctor: Former Patient: Phone Book: Internet: Ins. Co:

Referring Doctors Name/address & Phone # _____

Family Doctors name/address & Phone #: _____

Other Doctors name/address & Phone #: _____

Present Illness: **PLEASE CIRCLE ALL THAT APPLY**

Neck pain: Y N pain is: mild/moderate/severe/excruciating/dull/sharp/constant

Any radiation of pain/aching/burning? Y N into: shoulder/ scapula/ chest/ upper arm/ elbow/ forearm/ hand
fingers (thumb/ index/ middle/ ring/ little)/back of head (**left,right,bilateral**)

is radiation: mild/moderate/severe/excruciating/dull/sharp/constant

Any? Tingling/numbness If yes location: shoulder/ scapula/ chest/ upper arm/ elbow/ forearm/ hand
fingers (thumb/ index/ middle/ ring/ little)/ (**left,right,bilateral**) /genitals

Any? Weakness/stiffness If yes location: grip/fingers/arms/hands/legs (**left,right,bilateral**)

Date of onset: _____ Injury related: Yes No How _____

Symptoms began with: lifting/ work accident/ auto accident/ other liability/ spontaneous/ awoke with
symptoms/gradual onset/ other: _____

Symptoms **aggravated** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/
sex/ sleeping/ resting/ urination/ bowel movements

Symptoms **improved** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/
sex/ sleeping/ resting/ urination/ bowel movements

Any other associated symptoms?: chest pain/ headache/ bowel or bladder disturbance/ difficulty
with walking or balance/falling/double vision/ ringing in ears/

Any other symptoms? No Yes: _____

Treatments tried: none/ anti-inflammatory/ narcotics/ muscle relaxants/ antidepressants/ physical therapy
Epidural steroid injections/ pain injections/ chiropractor/ massage therapy/
Acupuncture/ nerve injections/ facet injections/ surgery

Are activities restricted? No Yes: limited working/ not working/ limited housework/ no housework
limited sports activity/ no sports activity/yard work/ shopping/ no
exercising/ limited exercising/ driving /other _____

Any prior history of above complaints? No Yes: -if yes- How long _____
Explain prior complaints: _____

Tests performed: none/ spine x-ray/ EMG/ nerve conduction studies/ CT scan/ MRI/ myelogram and
CT scan/ PET scan/ bone scan/ bone density/ diskogram/ facet injection/
nerve injection