Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Cervical Spine History

Please answer every question

To reproduce, follow the printing instructions.
Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

NECK PAIN

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

PAIN BETWEEN SHOULDER BLADES

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

RIGHT ARM PAIN

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

LEFT ARM PAIN

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

RIGHT SHOULDER PAIN

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

LEFT SHOULDER PAIN

CHARACTER: burning ○ aching ○ stabbing ○ other ○
FREQUENCY: none ○ occasional ○ frequent ○ constant ○
INTENSITY / SEVERITY: 0 = no pain 0 1 2 3 4 5 6 7 8 9 10 10 = worst pain imaginable

Does your arm pain radiate from neck into the arm and hand?
RIGHT SIDE yes ○ no ○
LEFT SIDE yes ○ no ○

Is the pain worsened by neck motion?
RIGHT SIDE yes ○ no ○
LEFT SIDE yes ○ no ○

Is the pain worsened by bending, twisting or turning?
RIGHT SIDE yes ○ no ○
LEFT SIDE yes ○ no ○

Does the pain worsen with lifting and moving the arm?
RIGHT SIDE yes ○ no ○
LEFT SIDE yes ○ no ○

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Direction of Feed

Cervical Spine History

Please answer every question

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Do not fold this form.

Is pain aggravated by:

COMPUTER WORK	yes ◯	no ◯
DRIVING	yes ◯	no ◯
READING	yes ◯	no ◯
EXTENSION	yes ◯	no ◯
FLEXION	yes ◯	no ◯

Do you have a loss of hand dexterity?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have muscle weakness in your HANDS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have muscle weakness in your ARMS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have muscle weakness in your LEGS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have muscle weakness in your FEET?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have numbness in your HANDS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have numbness in your ARMS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have numbness in your LEGS?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Do you have numbness in your FEET?

RIGHT SIDE	yes ◯	no ◯
LEFT SIDE	yes ◯	no ◯

Is your walking impaired? yes ◯ no ◯

Is your balance impaired? yes ◯ no ◯

Are you experiencing incontinence?

BOWEL	yes ◯	no ◯
BLADDER	yes ◯	no ◯

Are you experiencing any impotence or sexual dysfunction? yes ◯ no ◯