

NECK AND UPPER BACK PAIN INFORMATION

Date Filled Out _____

Age _____ Birthdate _____ Gender M F
Last Name First Name MI

Occupation: _____

What is your **Main Problem?** (Check all that apply)

- Neck Pain
- Headaches
- Shoulder Pain
- Arm Pain
- Upper Back Pain
- Mid Back Pain

If you have Arm Pain which is worse?

- I Don't have Arm Pain
- Both Arms hurt about Equally
- Both, Right Worse than Left
- Both, Left Worse than Right
- Right Arm Pain Only
- Left Arm Pain Only

How many weeks, days or months ago did this start? _____

What Caused This Problem?

- I Don't Know
- Car Accident
- A Fall
- Lifting
- Sports Injury
- Other: _____

Did it Start **Gradually or Suddenly?**

- Gradually
- Suddenly

Have you **seen any other Doctors for this?** Yes No

If Yes **Names** In Order that you saw them please.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Who Is Your **Primary Doctor?**

What Tests Have You Had Done For This?

- X-rays
- Blood Tests
- MRI
- CAT Scan
- Myelogram
- Bone Scan
- Discogram
- EMG
- Nerve Root Block

What Treatments Have You Had For This?

- Nothing
- Rest
- Pain Medicines
- Muscle Relaxers
- Anti-Inflammatories
- Physical Therapy
- Back Exercises
- Epidural Steroid Injection
- Prednisone
- Massage
- Chiropractic
- Traction
- Cervical Collar
- Other: _____

Do you get any **Regular Exercise?** Yes No

If Yes What? _____

How Many days per Week? _____

Current Symptoms

Which of these **Symptoms** do you have **now?**

- Neck Pain
- Shoulder Pain Rt. Lt.
- Arm Pain Rt. Lt.
- Numbness Where: _____
- Tingling Where: _____
- Arm or Leg Muscle Weakness
- Explain: _____
- Trouble Controlling Bowels or Bladder
- Pain with Coughing, Sneezing or Straining
- Pain that Wakes you from Sleep

Is Your **Neck Pain or Arm Pain Worse?**

- Neck Pain Worse than Arm Pain
- Arm Pain Worse Than Neck Pain
- Neck Pain about Equal to Arm Pain

Is Your Neck Pain: Aching Burning Stabbing Sharp Dull Stiff Pins and Needles
Timing: Worse in the: Morning Evening Nighttime Mid Day
Is Your Arm Pain: Aching Burning Stabbing Sharp Dull Stiff Pins and Needles
Timing: Worse in the: Morning Evening Nighttime Mid Day

What Makes Your Pain **Worse**?

Sitting
Standing
Walking
Lying Down
Exercise
Lifting
Looking Down
Looking Up
Working

What Makes Your Pain **Better**?

Sitting
Standing
Walking
Lying Down
Exercise
Pain Medicine
Anti-Inflammatories
Massage

Do You Have Any of the Following **Symptoms** ? (Check all that apply.)

Feeling Sick Weight Loss Fevers Shaking Chills Nausea
 Morning Stiffness
 Electrical Shock Feelings Visual Disturbance Balance Problems
 Trouble Writing Difficulty with fine manipulations
 Buzzing Sensation in Arms or Legs

Are You Taking Any **Medications For This** Now?

Medication Name Pills Per Day
 1) _____
 2) _____
 3) _____
 4) _____

Recently Are Your Symptoms ?

Getting Worse
 Staying About the Same
 Getting Better

Previous Neck Problems

Have You Had **Neck Problems Before** This? Yes No If Yes How many years ago did it start? _____

Have You Had **Surgery on Your Neck** Before? Yes No

If Yes Please List the Type of **Operation**, Approximate Year, and Doctor's Name

Operation	Year	Doctor
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Social History

How Far Did You Get In **School**?
 Didn't Graduate High School HS Grad
 Some College College Grad
 Professional or Advanced Degree
 Are You **Married**? Yes No
 How Many **Children**? 1 2 3 4 5 6
 Are You **Working**? Disabled Retired Working
 Parenting Taking Time Off Unemployed

Previous Medical Problems

Please Check Any Medical Problems You Have Had or Currently Have

Cardiac

Hypertension
 Coronary Artery Disease
 Myocardial Infarction
 Congestive Heart Disease
 Atrial Fibrillation
 High Cholesterol

Respiratory

COPD
 Asthma

Endocrine

Diabetes
 Hypo- Thyroidism
 Hyper – Thyroidism

GI

Irritable Bowel Syndrome
 Colon Cancer
 Diverticulitis
 GE Reflux
 Hepatitis
 Ulcer Disease

Urinary and Genital

Enlarged Prostate
 Kidney Stone
 Urinary Tract Infection
 Prostate Cancer
 Bladder Cancer
 Renal Cancer
 Ovarian Cancer
 Uterine Cancer

Musculoskeletal

Degenerative Arthritis
 Of: _____
 Rheumatoid Arthritis
 Fibromyalgia
 Neck Pain
 Upper Back Pain

Skin

Melanoma
 Other Skin Cancer
 Psoriasis

Neurologic

Multiple Sclerosis
 Parkinson's
 Stroke
 Peripheral Neuropathy

Psychiatric/ Emotional

Alcoholism
 Drug Use / Abuse
 Depression
 Anxiety Disorder
 Bipolar Disorder

Blood Disorders

HIV
 Bleeding Disorder
 Anemia
 Leukemia
 Lymphoma

Ear/Nose/ Throat

Lip/ Tongue or Throat Cancer
 Chronic Sinusitis
 Hearing Problems

Enter **Any Other Medical Problems Not Listed** Above Here: _____

Please List Any **Allergies to Medicines?** _____

Please List **All Regular Medications?** _____

Do You **Smoke?** Yes No If Yes, How many packs per Day: _____

Alcohol: How Many **Drinks**, Glasses of Wine or Beers **per Day:** **Never** <1 1 2 3 4 5

Any **Medical Problems That Run in The Family?** _____

Review Of Systems

Circle Any Symptoms you have now.

Cardiac	Chest Pain	Leg Swelling	Irregular Heart Beats	Shortness of Breath Lying Down
Respiratory	Wheezing	Chronic Cough	Feeling Short of Breath Easily or at Rest	
GI	Heartburn	Blood In Stool	Black or Tarry Stools	Constipation
Urologic	Burning with Urination	Trouble With Urinary Stream	Blood in Urine	Frequent Urination
Musculoskeletal	Joint Pain or Swelling	Lower Back Pain	Severe Morning Stiffness	
Endocrine	Excessive Thirst	Weight Gain	Excessive Fatigue	Excessive Urination
Hematologic	Bleeding Problems	Easy Bruising		
Psychologic	Crying Frequently	Feeling Worthless	Lack of Libido	Trouble Sleeping
ENT	Eye Pain	Wear Corrective Lenses	Trouble Hearing	Sinus Congestion
Gynecologic	Pelvic Pain	Symptoms of pregnancy	Uterine Bleeding	Vaginal Discharge

Any other symptoms you would like to mention? _____

PATIENT PAIN DRAWING

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
 Mark the areas of radiation. Include all affected areas. To complete the picture please draw in your face.

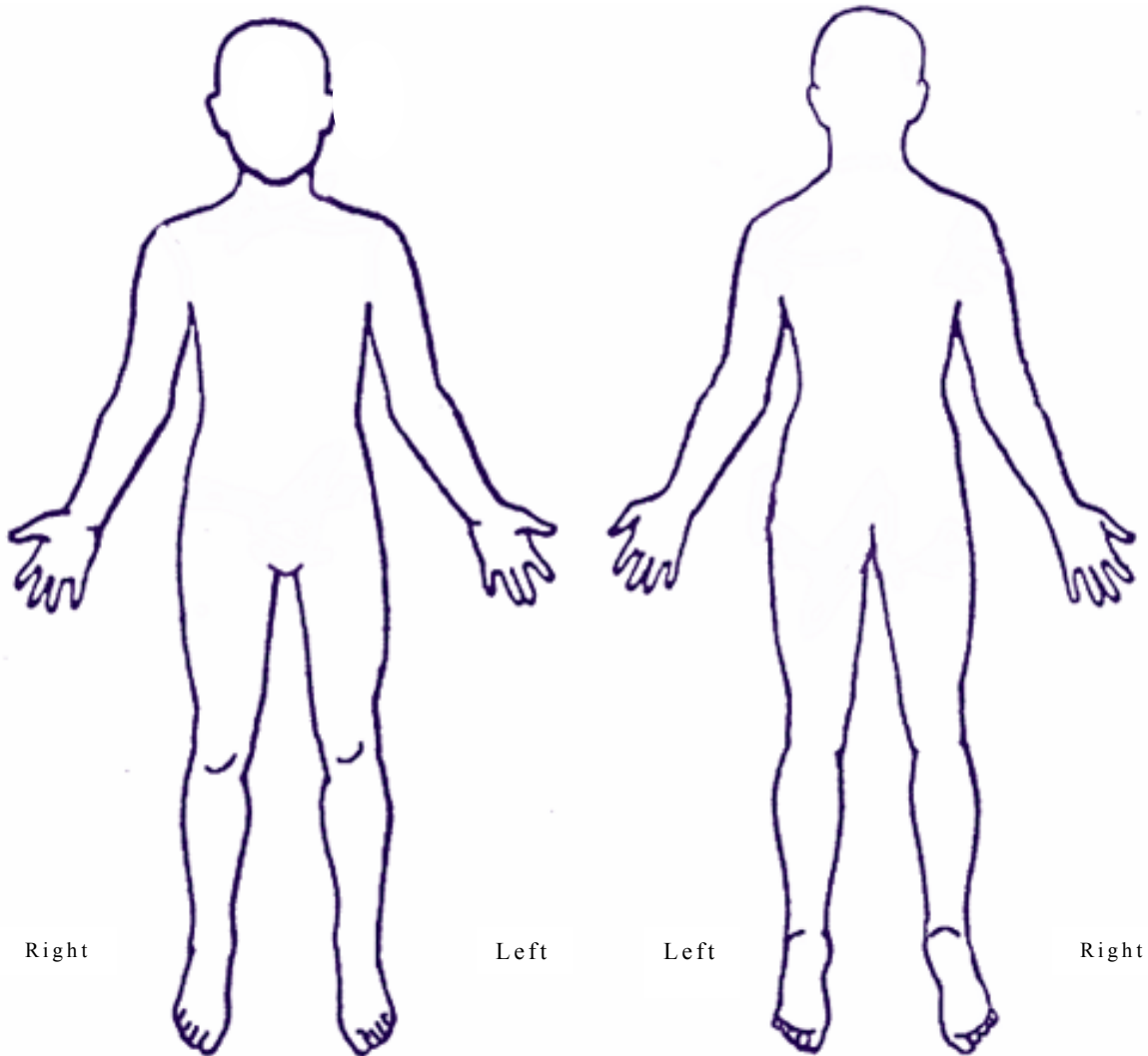
Aching
 ▲▲▲

Numbness
 = = =

Pins and needles
 O O O

Burning
 X X X

Stabbing
 / / /



How bad is your pain now?

Please mark and + on the body form where the pain is worst now

Please Mark on the line below how bad your pain is now

No Pain _____ Worst possible pain