Patient Questionnaire - Upper Quarter and Cervical Spine

Date: _____

(Please be thorough and fill out all that is applicable)

Patient (print): _____ **Date of Birth:** _____ **Age:** _____

Date of Injury or Onset of Symptoms: _____ **Return to Doctor Appointment:** _____

Date of Surgery: _____ **Type of Surgery:** _____

Please provide a brief history of your present condition and how did this begin: _____

_____

Your primary concern/chief complaint about your *CURRENT* condition: _____

_____

***CURRENT* Limitations of Function — Check *ALL* areas you *ARE CURRENTLY LIMITED*:**

❑ Self Care: Cooking, Shopping, Cleaning
❑ Changing & Maintaining Body Position
❑ Mobility: Walking & Moving Around
❑ Carrying, Moving & Handling Objects

CURRENT* Level of Function —** (% of your ***normal ability): ❑ 0% (unable to care for self) ❑ 10% ❑ 25% ❑ 50% ❑ 75% ❑ 100% ❑ Other: ___%

Pain Location: (*be specific*): ❑ Left ❑ Right ❑ Both: _____

_____

What is the intensity of your *PRIMARY SOURCE OF PAIN* (i.e., why you are beginning Hand Therapy)?

	0 = None				5 = Moderate					10 = Extreme
Circle your pain at its' ***LOWEST:***	0	1	2	3	4	5	6	7	8	9	10
Circle the pain you have ***RIGHT NOW:***	0	1	2	3	4	5	6	7	8	9	10
Circle your pain at its' ***HIGHEST:***	0	1	2	3	4	5	6	7	8	9	10

Describe your pain — Check *ALL* areas that apply:

❑ Burning ❑ Sharp ❑ Numbness/Tingling ❑ Throbbing ❑ Shooting
❑ Dull/Achy ❑ Other(s), Describe: _____
❑ If numbness, tingling, and/or shooting ***where does the pain START and END***? _____

_____

What aggravates your pain — Check *ALL* areas that *INCREASE(S)* your pain:

❑ Sitting ❑ Standing ❑ Sit-to-Stand ❑ Bending ❑ Walking
❑ Going to the Restroom ❑ Coughing/Sneezing ❑ Lying Down ❑ Driving ❑ Lifting/Carrying
❑ Other(s), Describe: _____

What can you do to decrease your pain — Check *ALL* areas that *DECREASE(S)* your pain:

❑ Sitting ❑ Standing ❑ Walking ❑ When Still ❑ Mornings ❑ Evenings
❑ Lying Down ❑ Movement: Describe: _____
❑ Other(s), Describe: _____

Name of Occupation: _____ **Out of Work Since:** _____ **Return to Work Date:** _____

Work Status — Check the *ONE* that best describes your status: ❑ Full Time ❑ Part Time
❑ Light Duty ❑ Transitional Duty ❑ Out of Work ❑ Retired ❑ Not Working ❑ Homemaker

Description of your Occupation: ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy ❑ Very Heavy

Is there an attorney involved? ❑ Yes ❑ No — **Who?** _____ **Attorney's Office #:** _____

Medical History — Check *ALL* that apply *AND* provide descriptions:

❑ Osteoarthritis _____

❑ Diabetes Mellitus: _____
If yes: ❑ Type 1 ❑ Type 2
Managed: ❑ Insulin ❑ Meds. ❑ Diet

❑ Currently Pregnant _____

❑ Cancer: _____

❑ Epilepsy/Seizures _____

❑ Migraines/Headaches _____
If yes, is the pain: ❑ Greater on one side
❑ Equal on both sides

❑ Prior Therapy: ❑ OT ❑ PT ❑ Chiropractic
For: _____

❑ Implantable medical device(s)_____
❑ Pacemaker
❑ Defibrillator
❑ Other: _____

❑ Cardiovascular Disease _____

❑ Emotional/Psychological _____

❑ Allergies _____

❑ Asthma _____

❑ Smoking: _____
If yes: Packs per day: _____
Quit? __ year(s) __ month(s) __ week(s) __ day(s)

❑ Dizziness/Fainting: Describe: _____
❑ Trigger(s):_____
❑ How Long Does the Dizziness Last:_____

❑ Surgical History_____

❑ Splint/Cast/Sling: If so, how long? _____
Type: _____

❑ History of Falls: ❑ Yes ❑ No, If Yes, Explain:
_____

Diagnostic Testing/Procedures — Check *ALL* that apply *WITH DATES & RESULTS:*

❑ CT - Date: _____ Results: _____

❑ MRI - Date: _____ Results: _____

❑ EMG - Date: _____ Results: _____

❑ Myelogram - Date: _____ Results:_____

❑ Bone Scan - Date: _____ Results: _____

❑ Other _____ - Date: _____ Results: _____

❑ Steroid Injections in Muscles - Date: _____
Results _____

❑ Epidural Steroid Injections - Date: _____
Results _____

Current Medications — Check *ALL* that apply *AND* provide dosages — Attach a list if necessary

❑ Not Currently Taking Any Medications ❑ Prescription_____

❑ Over The Counter_____ ❑ Herbals_____

❑ Vitamins & Minerals_____ ❑ Dietary & Nutritional Supplements _____

What are your Hobbies? _____

What are your Physical Therapy Goals? _____

Current Weight: _____ **Current Height**: _____

Neck Index

ACN Group, Inc. Form NI-100

(Neck Disability Index)

PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score