

## PAIN DRAWING

PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

### WHERE IS YOUR PAIN NOW?

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

ACHE	^^^	NUMBNESS	ooo	PINS & NEEDLES	■ ■ ■	BURNING	X X X	RADIATING PAIN	///
	^^^		ooo		■ ■ ■		X X X		///
	^^^		ooo		■ ■ ■		X X X		///

Neck Pain \_\_\_\_\_ %

Arm Pain \_\_\_\_\_ %

Back Pain \_\_\_\_\_ %

Leg Pain \_\_\_\_\_ %

**Total = 100%**

PLEASE MARK ON THE LINE:

How bad is your pain now?



Is your problem related to:

- Job Injury
- Car Accident

Is there any litigation pending?

- No
- Yes

Please describe car accident or job injury: \_\_\_\_\_

\_\_\_\_\_

Please describe your main problem:

\_\_\_\_\_

\_\_\_\_\_

How has this interfered with your life?

\_\_\_\_\_

\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_

My pain is best when      Walking      Standing      Sitting      Laying down

My pain is worst when      Walking      Standing      Sitting      Laying down

What else makes the pain better? \_\_\_\_\_

What else makes the pain worse? \_\_\_\_\_

How does coughing or sneezing affect the pain?      Worse      Better      No difference

How long can you stand with no or minimal pain? \_\_\_\_\_

How far can you walk with no or minimal pain? \_\_\_\_\_

Have you ever had any problems like this in the past or required hospitalization for this?

\_\_\_\_\_

\_\_\_\_\_

Have you seen any other doctors for this problem or had previous back/neck surgery?

Dr. \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_ Recommendation: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_ Recommendation: \_\_\_\_\_

Describe your treatment(s) to date (including injections, chiropractor/alternative treatments)

\_\_\_\_\_

\_\_\_\_\_

Which diagnostic tests were performed?

Xrays      Date \_\_\_\_\_      Results \_\_\_\_\_

CT scan      Date \_\_\_\_\_      Results \_\_\_\_\_

MRI      Date \_\_\_\_\_      Results \_\_\_\_\_

EMG      Date \_\_\_\_\_      Results \_\_\_\_\_

Discogram      Date \_\_\_\_\_      Results \_\_\_\_\_

Myelogram      Date \_\_\_\_\_      Results \_\_\_\_\_

DEXA Scan      Date \_\_\_\_\_      Results \_\_\_\_\_

*For office use only:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Please check below any condition that applies and add any comments that apply.

	YES	NO	Comments		YES	NO	Comments
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Bleeding Disorder				Immune Disorder			
Bowel Disorder				Kidney Disorder			
Cancer				Liver Disease			
Depression				Rheumatoid Arthritis			
Diabetes				Stroke			
Drug/Alcohol Abuse				Thyroid Disease			
Epilepsy				Tuberculosis			
Heart Disease				Ulcers			
Other (describe):							

Previous Hospitalizations, major surgeries, serious infections and approximate dates

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## SOCIAL HISTORY

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Highest education level \_\_\_\_\_

Work Status:  Full Duty  Light Duty  Off Duty (per M.D.)  Unemployed  Retired

If you are not working full duty, how long have you been off work? \_\_\_\_\_

Tobacco  YES  NO

Cigarettes Pack(s) per day \_\_\_\_\_ How many years \_\_\_\_ If you quit, when? \_\_\_\_\_

Other tobacco Amount per day \_\_\_\_\_ How many years \_\_\_\_ If you quit, when? \_\_\_\_\_

Alcohol  YES  NO

If yes, how often and how much \_\_\_\_\_

Have you ever received formal treatment for dependency \_\_\_\_\_

Do you currently or have you ever used any recreational drugs?  YES  NO

If yes, please list all and how often \_\_\_\_\_

# FAMILY HISTORY

Please list health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

## SYSTEM REVIEW Please answer yes or no with a check mark or X.

<b>Constitutional</b>			<b>GenitoUrinary</b>		
Recent weight changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bloody urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent fevers/chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning with urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Eyes, Ear, Nose, Throat</b>			Unable to control bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unable to control bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal periods (women)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Neurological</b>		
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness/tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Respiratory</b>			Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breathing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crying problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Skin</b>		
<b>Cardiovascular</b>			Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Non-healing wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty exercising	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Easy bruising/bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of feet/hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Musculoskeletal</b>		
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint pain/swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Gastrointestinal</b>			Muscle pain/cramping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Endocrine</b>		
Bleeding ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excess thirst/urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bloody stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Allergic</b>		
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent cold/flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay/dust fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)**

I have personally reviewed and discussed all the preceding information with my patients.

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

# MEDICATIONS FORM

List all medications – please include dosages and frequency

Medications	Dosage	Medications	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU CURRENTLY ON ANY TYPE OF BLOOD THINNER:  Yes  No

Medication	3	Helpful?	Medication	3	Helpful?	Medication	3	Helpful?
Aspirin			Glucosamine			Prozac		
Bextra			Ibuprofen			Relafen		
Celebrex			Lortab			Skelaxin		
Darvocet			Mobic			Soma		
Demerol			Motrin			Tylenol		
Dilaudid			Naprosyn			Tylenol #3		
Duragesic			Oxycodone			Valium		
Elavil			Oxycontin			Vicodin		
Flexeril			Predisone			Vioxx		

## Allergies

Please list all medications you have allergies to and the type of reaction

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)**

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I have personally reviewed and discussed the medication and allergy information with my patient.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

# NECK PAIN DISABILITY INDEX

(Oswestry 2.0)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

## Section 1 – Pain intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

## Section 2 – Personal care (Washing, Dressing, etc.)

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

## Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently
- I can lift very light weights
- I cannot lift or carry anything at all

## Section 4 – Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want to with moderate pain in my neck
- I can't read as much as I want because of pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

## Section 5 – Headaches

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all the time

**Section 6 – Concentration**

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

**Section 7 – Work**

- I can do as much work as I want to
- I can only do my usual work but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do work at all

**Section 8 – Driving**

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I cannot drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all

**Section 9 – Sleeping**

- I have no problem sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-6 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

**Section 10 – Recreation**

- I am able to engage in all my recreational activities with no neck pain at all
- I am able to engage in all my recreational activities with some pain in my neck
- I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
- I am able to engage in few of my usual recreational activities because of pain in my neck
- I can hardly do any recreational activities because pain in my neck
- I cannot do any recreational activities at all

Please describe how you have felt during the PAST WEEK by marking a check mark (✓) in the appropriate box. Please answer all questions. Do not think too long before answering.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
Heart rate increase				
Sweating all over				
Sweating in a particular part of the body				
Pulse in neck				
Pounding in head				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal				
Nausea				
Butterflies in stomach				
Pain or ache in stomach				
Stomach churning				
Desire to pass water (urinate)				
Mouth becoming dry				
Difficulty swallowing				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles				

Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
I feel downhearted and sad				
Morning is when I feel best				
I have crying spells or feel like it				
I have trouble getting to sleep at night				
I feel that nobody cares				
I eat as much as I used to				
I still enjoy sex				
I notice I am losing weight				
I have trouble with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be				
I tend to wake up too early				
I find it easy to do the things I used to				
I am restless and can't keep still				
I feel hopeful about the future				
I am more irritable than usual				
I find it easy to make a decision				
I feel quite guilty				
I feel that I am useful and needed				
My life is pretty full				
I feel that others would be better off if I were dead				
I am still able to enjoy the things I used to				