

**NEW HAMPSHIRE NEUROSPINE INSTITUTE
INITIAL NECK & BACK EVALUATION**

Today's Date: _____ Medical Records #: _____
 Last Name: _____ First Name: _____
 Date of Birth: _____ Age: _____ Male _____ Female _____
 Height: _____ in. Weight: _____ lbs.
 Primary Care Physician (PCP): _____ Physician Specialists: _____
 Referred by: _____

History:
 Date of injury or when pain began: ____ / ____ / ____
 Describe how injury occurred or how the symptoms began: _____

Did this happen at work? Yes No

Answer the following questions if this is a work related injury:
 Name of employer where injury occurred: _____
 Job title at time of injury: _____
 What is your current work status: Out of work
 Working with restrictions _____ hrs/day _____ days/wk _____ lbs. max
 Fully Duty Other _____
 How long had you worked at this job before the injury occurred:
 Prior to this injury, were you working: Fully Duty Limited / Modified Duty

Where did you first seek treatment: _____

What other treatments have you tried: (fill in number of weeks) None
 Chiropractor _____ wks Physical Therapy _____ wks Pain Center _____ wks
 Spinal Injections _____ wks Oral Steroids _____ wks PCP _____ wks

If you have had physical therapy, please fill in what you have tried:
 Massage Ultrasound Heat Ice Electrical Stimulation Pool therapy Treadmill
 Exercise bike Stairmaster Stretching Myofascial release Weights Nautilus
 Home exercise program Work hardening

What diagnostic tests (related to your neck or back) have you had: (fill in approximate dates {month/year})
 MRI ____ / ____ CT Scan ____ / ____ Myelogram ____ / ____ Bone Density ____ / ____
 Discogram ____ / ____ Bone Scan ____ / ____ EMG's ____ / ____

Have you had neck / back symptoms before this episode:
 No One episode Multiple episodes Most recent date: ____ / ____ / ____

Complete the following if you have had neck or back surgery:
 Describe type of surgery, date, surgeon:
 _____ / ____ / ____ _____
 procedure date surgeon
 _____ / ____ / ____ _____
 procedure date surgeon
 _____ / ____ / ____ _____
 procedure date surgeon
 Have you had an infection related to neck / back surgery: No Yes
 Were you able to return to work after the most recent surgery:
 No Yes, with limits Yes, no limits Homemaker Student Retired

Present Neck Status:

Describe your pain in relation to how much is neck pain and how much is arm pain:

- All neck pain Mostly neck pain / some arm pain Equal neck and arm pain
Mostly arm pain / some neck pain All arm pain
Quality of Pain: Aching Burning Sharp Dull

Answer the following questions regarding your arm symptoms:

- I don't have arm symptoms
- Do you have **arm pain**:
- {Choose one} Constantly It comes and goes
{Choose one} Left arm Right arm Both arms
- Do you have **arm numbness/tingling**:
- {Choose one} Constantly It comes and goes
{Choose one} Left arm Right arm Both arms
- Do you have **arm weakness**:
- {Choose one} Constantly It comes and goes
{Choose one} Left arm Right arm Both arms

What makes your pain worse:

- Lifting Coughing Sneezing Driving Flexing neck Extending neck
Turning head to left Turning head to right

What relieves your pain:

- Lowering arm Raising arm overhead Flexing neck Extending neck
Changing positions Nothing

Describe your pain (neck and/or arm) on a scale of 0-10 (0 = no pain at all; 10 = the worst pain you can imagine):

- At its worst: _____
Most of the time: _____
At its best: _____

Do you use any assistive devices:

- No Cane(s) Crutches Wheelchairs Tens Unit Neck brace
Other _____

Present Back Status:

Describe your pain in relation to how much is back pain and how much is leg pain:

- All back pain Mostly back pain / some leg pain Equal back and leg pain
Mostly leg pain / some back pain All leg pain
Quality of Pain: Aching Burning Sharp Dull

Answer the following questions regarding your leg symptoms:

- I don't have leg symptoms
- Do you have **leg pain**:
- {Choose one} Constantly It comes and goes
{Choose one} Left leg Right leg Both legs
- Do you have **leg numbness/tingling**:
- {Choose one} Constantly It comes and goes
{Choose one} Left leg Right leg Both legs
- Do you have **leg weakness**:
- {Choose one} Constantly It comes and goes
{Choose one} Left leg Right leg Both legs

What makes your pain worse:

- Lifting Bending Twisting Sitting Driving Standing Walking
Coughing Sneezing Getting up from a chair

What relieves your pain:

- Lying on back Lying on side Lying on stomach Bending knees Sitting
Standing Walking Changing positions Nothing

Describe your pain (back and/or leg) on a scale of 0-10 (0 = no pain at all; 10 = the worst pain you can imagine):

- At its worst: _____
Most of the time: _____
At its best: _____

Do you use any assistive devices:

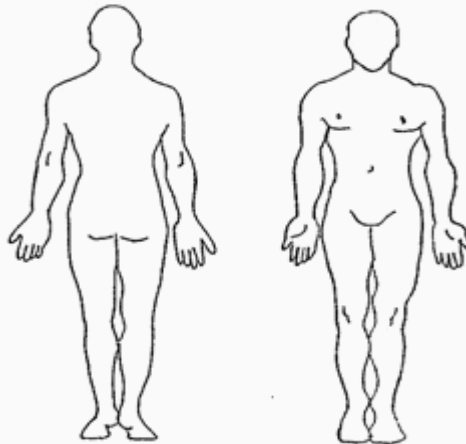
- No Cane(s) Crutches Wheelchairs Tens Unit Back brace
Other _____

SHOW US WHERE YOUR PAIN IS LOCATED

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.)

P = PAIN

N = NUMBNESS (Numbness is the loss of sensation or the feeling of being "asleep" - it is not painful.)



Medical History: (check all that apply) Do you have or have you had any of the following?

No medical conditions

- Diabetes Heart Disease Stroke Asthma Depression Hepatitis High Blood Pressure GERD
 Lung Disease Alcohol Abuse Ulcer Disease Vascular Disease Thyroid Disease Osteoporosis
 Tuberculosis Arthritis High Cholesterol Anxiety ADD/ADHD

Cancer (type: _____) Other: _____

Have you had any previous surgery: (add dates) None

- | | | | | | |
|---------------------------------------|-------|---------------------------------------|-------|--|-------|
| Tonsils <input type="checkbox"/> | _____ | Appendectomy <input type="checkbox"/> | _____ | Gallbladder <input type="checkbox"/> | _____ |
| Hysterectomy <input type="checkbox"/> | _____ | Heart <input type="checkbox"/> | _____ | Blood vessels <input type="checkbox"/> | _____ |
| Lung <input type="checkbox"/> | _____ | Kidney <input type="checkbox"/> | _____ | Stomach or intestinal <input type="checkbox"/> | _____ |
| Other(s): <input type="checkbox"/> | _____ | | | | |

List all of your current medications (Please include dosage and frequency):

No medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____

Location: _____

Do you have any drug allergies: None

If yes please list and describe what happens: _____

Social History:

Marital Status: Single Married Divorced Separated Widowed

Do you have any children: No Yes (number: _____)

Living situation: Live with spouse Live with significant other Live alone Nursing home
 Live with parents Live with adult children Live with minor children

Smoking: Never smoked Quit _____ months ago Quit _____ years ago Yes _____ pks per day x _____ yrs.

Do you drink alcohol: No Yes If yes, how much alcohol do you drink each day: _____ drinks/day.

Have you had any weight changes in the past year: No Yes, gained _____ lbs. Yes, lost _____ lbs.

What is the last grade you completed:

- _____ Grade GED High School Graduate 2-yr Associates Degree Technical School
 _____ yrs. College Bachelors Degree Post Graduate or Professional Degree

What is your race?: American Indian or Alaskan Native Asian Black or African American White
 Native Hawaiian or other Pacific Island Unknown/Decline to answer

What is your Ethnicity?: Arab-American Hispanic or Latino Not Hispanic or Latino Unknown/Decline to answer

What is your language preference? : _____

Family History:

Do any of these diseases run in your immediate family (parents, brothers and sisters only):

No medical conditions

- Diabetes Heart Disease Stroke Asthma Depression Hepatitis B High Blood Pressure
 Lung Disease Alcohol Abuse Ulcer Disease Vascular Disease Thyroid Disease Arthritis
 Chronic Pain
 Cancer (type: _____) Other: _____

Work History: (Skip this section if already answered on page one)

Present employer: _____

Primary occupation: _____

How long have you worked at your current job: _____ months _____ years

Current work situation:

- Working Paid leave Unpaid leave Unemployed Homemaker Student
 Permanently disabled / retired due to neck/back Permanently disabled / retired for other health reasons
 Retired not due to health

Exercise Habits:

Do you routinely exercise? If so, how often?:

Current Functional Status:

Which of these functions are you presently able to perform:

- Personal hygiene Cooking Light house cleaning (sweeping/dusting) Laundry
 Heavy housework (vacuuming) Yardwork Driving ___ min. Sitting ___ min.
 Walking ___ min. Standing ___ min. Lifting ___ lbs.

Review of Systems: Please check any condition you are currently experiencing.

- | | | | |
|--|--|---|--|
| Recent nausea or vomiting <input type="checkbox"/> | Loss of hearing <input type="checkbox"/> | Frequent headaches <input type="checkbox"/> | Incontinence of bowel <input type="checkbox"/> |
| Hot or cold spells <input type="checkbox"/> | Nosebleeds <input type="checkbox"/> | Blackouts <input type="checkbox"/> | Incontinence of bladder <input type="checkbox"/> |
| Swollen ankles <input type="checkbox"/> | Stomach pain <input type="checkbox"/> | Seizures <input type="checkbox"/> | |
| Difficulty swallowing <input type="checkbox"/> | Ulcers <input type="checkbox"/> | Recent weight change <input type="checkbox"/> | |
| Morning cough <input type="checkbox"/> | Fever or chills <input type="checkbox"/> | Nervous exhaustion <input type="checkbox"/> | |
| Shortness of breath <input type="checkbox"/> | Constipation <input type="checkbox"/> | Claustrophobia <input type="checkbox"/> | |
| Heart or chest pain <input type="checkbox"/> | Poor appetite <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | |
| Abnormal heartbeat <input type="checkbox"/> | Burning urination <input type="checkbox"/> | Metal in eye <input type="checkbox"/> | R or L <input type="checkbox"/> |
| Calf cramps w/ walking <input type="checkbox"/> | Recent diarrhea <input type="checkbox"/> | | |

If you checked any of the above, have you discussed the problem(s) with your primary doctor? Yes No

MD USE ONLY

RX:

Vital signs:

MD Notes:

Who is accompanying a minor?