SOUTHERN CALIFORNIA SPINE & JOINT INSTITUTE

NECK PAIN

Please mark the appropriate boxes below

Name: _____DOB: _____

1. **When did you first start feeling the current episode of your neck pain?**

   ☐_____Weeks ☐_____months ☐_____years

   a. Did this pain begin after a significant trauma or injury? If so, please describe:

   _____

2. **Where is your neck pain located?**

   ☐ Both sides equally ☐Right side ☐Left side

3. **Does your neck pain radiate down into your arms or hands?** ☐ Yes ☐ No **If yes, where?**

☐Right Shoulder	☐Left Shoulder	☐Both shoulders
☐Right arm	☐Left arm	☐Both arms
☐Right elbow	☐Left elbow	☐Both elbows
☐Right forearm	☐Left forearm	☐Both forearms
☐Right hand	☐Left hand	☐Both hands

4. **Do you have any numbness or tingling in your arm or hand?** ☐ No ☐ If yes, where?

☐Left arm	☐Right arm	☐Both Arms
☐Left hand	☐Right hand	☐Both hands

5. **Can you describe your pain?**

   ☐Aching ☐Burning ☐Dull ☐Sharp ☐Shooting ☐Stabbing ☐Throbbing ☐Tightness

6. **In the past week, how would you grade the severity of your neck pain <u>on average</u> on a scale from 0 to 10? Zero being nothing.** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. **Do you get headaches with your neck pain?** ☐ Yes ☐ No

   a. **If yes, how often? _____**

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8. **Are you currently taking any medication(s) to treat your neck pain? If yes, please list below or provide list.**

Medication	**Dose**	**How often?**
_____	_____	_____
_____	_____	_____

9. **Is there anything you do that makes the neck pain worse?** ☐ No ☐ If yes, what?

☐Looking up ☐Looking down ☐Looking left ☐Looking right ☐Driving ☐Working

☐Sitting for too long ☐Standing for too long ☐Lifting ☐Sleeping ☐Yard work

☐Housework ☐Exercising ☐Performing sitting to standing transfers

10. **Have you tried any treatments in the past for your pain?** ☐No ☐ **If yes, what treatments?**

☐Physical Therapy ☐TENS unit ☐Neck Surgery ☐Epidural Steroid Injection(s)

☐Chiropractic ☐Acupuncture ☐Nerve Blocks ☐Radiofrequency ablation ☐Massage

☐Home exercise ☐Traction ☐Ice ☐Heat

a. **If you've participated in physical therapy, when was the last time you did so?**

_____

b. **If you've had epidural steroid injections, when was your last one?**

_____

Diagnostic Studies

Have you had any recent radiologic exam(s) related to your neck pain? ☐ No ☐ If yes, please mark:

☐MRI ☐ CT Scan ☐ X-Ray ☐ Ultrasounds ☐ Bone Scan

Allergies

Please list any known allergies, if none please write none:

_____

_____

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Medication History

1. **Please list ALL medications you are taking, if any:**

Medication	**Dose** (mg, mcg…)	**How often** (once, twice, 3 times daily…)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. **Do you take any blood thinning medication (i.e. Coumadin, Plavix, Aspirin)?**

☐No ☐ Yes **If yes, medication name:** _____

   a. **Who is the cardiologist or doctor that prescribes this medication?**

   Name_____ Phone #_____

3. **What pharmacy would you like medications sent to if necessary?**

Pharmacy: _____ City: _____

Cross Streets: _____

Medical History

Please list all <u>past and present medical problems / medical history</u>, including mental or psychological problems: (high blood pressure, high cholesterol, diabetes, heart attack, stroke, lung disease…)

☐High Blood Pressure ☐High Cholesterol ☐Diabetes (Type 1 / Type 2) ☐Heart Attack

☐ Stroke ☐COPD ☐Congestive Heart Failure ☐Coronary Artery Disease ☐Anxiety / Depression

☐Asthma ☐HIV ☐Hepatitis (A / B / C) ☐Blood Clots ☐Acid Reflux

☐Gout ☐ Thyroid Disease ☐Other (please list): _____

_____

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Have you ever been diagnosed with any tumors or cancer? □ No □ Yes

If yes, what kind? _____

Social History

1. **Do you currently smoke tobacco?** □ No □ Yes / Every day. □ Yes / Somedays □ Former Smoker
2. **Do you currently drink alcohol?** □ No □ Yes: **How often?** □ Social □ Occasional □ Heavy □ Light

   What do you usually drink? □ Beer □ Wine □ Hard Liquor
3. **Do you have any history of alcohol abuse?** □ Yes □ No
4. **Do you have a history of substance abuse or substance use disorder?** □ Yes □ No
   a. **If yes, what substance?** _____

Surgical History

Please list all past surgeries you have had (appendix, tonsils, cataracts, gall bladder, etc):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signature _____ Date: _____