NEW HAMPSHIRE NEUROSPINE INSTITUTE
INITIAL NECK & BACK EVALUATION

Last Name: _____ First Name: _____ Today's Date: ___ / ___ / ___
Date of birth: ____ / ____ / ____ Age: _____
Male ☐ Female ☐ Height: _____ ft _____ 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.
Full duty ☐ Other ☐ _____
How long had you worked at this job before the injury occurred: _____
Prior to this injury, were you working: Full 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 ☐ #_____ 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
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____

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 ☐

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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 ☐

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**:

{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 left ☐ Turning head 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 ☐

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**:

{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 ☐ _____

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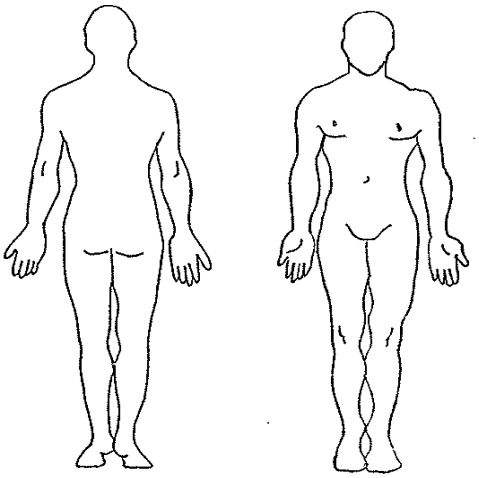
SHOW US WHERE YOUR PAIN IS LOCATED

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 ☐

Lung disease ☐ Alcohol abuse ☐ Ulcer disease ☐ Vascular disease ☐ Thyroid disease ☐ Osteoporosis ☐

Tuberculosis ☐ Arthritis ☐

Cancer ☐ (type: _____) Other: _____

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

Tonsils ☐ _____ Appendectomy ☐ _____ Gall Bladder ☐ _____

Hysterectomy ☐ _____ Heart ☐ _____ Blood vessels ☐ _____

Lung ☐ _____ Kidney ☐ _____ Stomach or intestinal ☐ _____

Other(s): _____ _____ _____ _____

List all of your current medications: No medications ☐

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any drug allergies: None ☐

Yes ☐ List: _____

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 ☐

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 ☐

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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 ☐
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 back ☐ Permanently disabled/retired other health reasons ☐
Retired not due to health ☐

Leisure Activities:

Prior to your neck or back injury/ problem, what leisure activities did you regularly participate in: (list below)

_____
_____
_____

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 <u>currently</u> experiencing.*

	Yes	No		Yes	No		Yes	No	
Recent nausea or vomiting	☐	☐	Loss of hearing	☐	☐	Frequent headaches	☐	☐	
Hot or cold spells	☐	☐	Nosebleeds	☐	☐	Blackouts	☐	☐	
Swollen ankles	☐	☐	Stomach pain	☐	☐	Seizures	☐	☐	
Difficulty swallowing	☐	☐	Ulcers	☐	☐	Recent weight change	☐	☐	
Morning cough	☐	☐	Fever or chills	☐	☐	Nervous exhaustion	☐	☐	
Shortness of breath	☐	☐	Constipation	☐	☐	Claustrophobia	☐	☐	
Heart or chest pain	☐	☐	Poor appetite	☐	☐	Pacemaker	☐	☐	
Abnormal heartbeat	☐	☐	Burning urination	☐	☐	Metal in eye	☐	☐	R or L
Calf cramps w/walking	☐	☐	Recent diarrhea	☐	☐				

If you check yes to any of the above, have you discussed the problem(s) with your primary doctor? ☐ ☐

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