

Neck Intake Form

Patient Name: _____

Date symptoms began: _____

Describe how symptoms began: _____

What treatment have you had for this problem?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Cervical collar |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Home traction | <input type="checkbox"/> Electrical Stimulation |

Have you had neck surgery? Yes No

What type of surgery and when? _____

Neck pain and arm pain:

- | | | |
|---|---|---|
| <input type="checkbox"/> All neck | <input type="checkbox"/> Mostly neck/some arm | <input type="checkbox"/> Equal neck and arm |
| <input type="checkbox"/> Mostly arm/some neck | <input type="checkbox"/> All arm | |

If you have arm symptoms:

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Constant | | <input type="checkbox"/> Intermittent (comes and goes) |

Rate the pain (neck and/or arm) on a scale of 0-10 (0 = no pain, 10 = worst pain imaginable)

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

What makes the pain worse:

- | | | | |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Looking right | <input type="checkbox"/> Looking left |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Bending forward | | <input type="checkbox"/> Bending backward |

What makes the pain better:

- | | | | |
|---|---------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Looking right | <input type="checkbox"/> Looking left | <input type="checkbox"/> Looking up | <input type="checkbox"/> Looking down |
| <input type="checkbox"/> Raising arm up | <input type="checkbox"/> Lowering arm | | |

What medications have you tried for this problem:

- | | | | |
|---------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Ultram | <input type="checkbox"/> Vicodin/hydrocodone | <input type="checkbox"/> Percocet/oxycodone | <input type="checkbox"/> Neurontin |
| <input type="checkbox"/> NSAIDs | <input type="checkbox"/> Medrol Dosepak (prednisone) | <input type="checkbox"/> Other _____ | |

What studies have you had for this problem?

- | | | | |
|------------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> MRI | <input type="checkbox"/> CT scan | <input type="checkbox"/> Nerve studies | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> Discogram | <input type="checkbox"/> Cortisone injections | | |