Do you have neck pain?

☐ Yes  ☐ No

If yes, please fill out the following in regards to your neck pain:

Cervical Visual Analog Scale (VAS) - (Please rate your pain on a scale of 0 to 10: 0 indicating no pain, 5 indicating moderate pain, and 10 indicating the worst possible pain. Please check only one box with the corresponding number.)

Left Shoulder Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Right Shoulder Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Left Arm Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Right Arm Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Left Hand Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Right Hand Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness

Cervical Pain VAS Pain Scale

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

☐ New Pain  ☐ Existing Pain  ☐ New Numbness  ☐ Existing Numbness
NECK DISABILITY INDEX
This questionnaire has been designed to give your health care provider information as to how your neck pain has affected your ability to manage in everyday life. Please answer every question by placing a mark on the line that best describes your condition today. You may feel that two of the statements may describe your condition, but please mark only the line which most closely describes your current condition.

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.

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.

Lifting
_____ I can lift heavy weights without increased pain
_____ I can lift heavy weights but it causes increased pain
_____ Pain prevents me from lifting heavy weights off of the floor, but can manage if they’re conveniently positioned (ex. on table)
_____ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
_____ I can lift only very light weights.
_____ I cannot lift or carry anything at all.

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 with moderate pain in my neck.
_____ I cannot read as much as I want because of moderate pain in my neck.
_____ I cannot read as much as I want because of severe pain in my neck.
_____ I cannot read at all.

Headache
_____ I have no headache 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.

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 concentrating when I want to.
_____ I cannot concentrate at all.

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 any work at all.

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 cannot drive my car at all.

Sleeping
_____ I have no trouble sleeping.
_____ My sleep is slightly disturbed (less than 1 hour sleep loss).
_____ My sleep is mildly disturbed (1-2 hour sleep loss).
_____ My sleep is moderately disturbed (2-3 hours sleep loss).
_____ My sleep is greatly disturbed (3-5 hours sleep loss).
_____ My sleep is completely disturbed (5-7 hours sleep loss).

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 a few of my usual recreational activities because of pain in my neck.
_____ I can hardly do any recreational activities because of pain in my neck.
_____ I cannot do any recreational activities at all.
Clinical Outcome Intake Form for new spine patients on first visit only.

Your care is very important to us. For us to manage your care, please answer all questions on this form.

1. **Patient information...**

   - Today’s Date: __________
   - First name: __________
   - Last name: __________
   - Phone number (A nurse may call to follow up): __________
   - Sex: □ Male □ Female
   - Your age: □ <18 □ 18-64 □ 65+
   - Day □ Evening
   - Do you smoke? □ Yes □ No
   - Doctor you will see today: __________

2. **Tell us about your symptoms...**

   - Do you have weakness in a foot or hand? □ Yes □ No
   - How long have you suffered from these symptoms? □ ≤ 6 weeks □ 7 to 12 weeks □ 4 months or more
   - Do you have pain radiating PAST your knee or elbow? □ Yes □ No
   - Does your leg or arm ever go numb? □ Yes □ No
   - Have you had back or neck surgery before? □ Yes □ No
   - Does your back or neck pain wake you up at night? □ Yes □ No
   - How many pills do you take each day for pain relief? □ No pills □ 1 to 4 pills □ 5 or more pills daily
   - Circle your pain level on a scale of 1 to 10, with 1 being no pain at all, and 10 being extreme pain.

3. **Your expectations...**

   - What result do you expect from your care?
     - Relief from pain symptoms: □ Yes □ No □ Doesn’t apply
     - Return to your job: □ Yes □ No □ Doesn’t apply
     - Return to leisure activities: □ Yes □ No □ Doesn’t apply
     - Improved sleep: □ Yes □ No □ Doesn’t apply

4. **How do symptoms affect your life...**

   - Which of the following describes you currently?
     - □ Working
     - □ Not working because of back or neck problem
     - □ Not working because of another health problem
     - □ Homemaker, retired or unemployed
   - Did your back or neck injury happen at work? □ Yes □ No
   - The following are activities you might do in a day. Does your back or neck pain limit you in these activities, and if so, how much?
     - Lifting or carrying groceries: □ Limited a lot □ Limited a little □ Not limited at all
     - Climbing several flights of stairs: □ Limited a lot □ Limited a little □ Not limited at all
     - Standing for 30 minutes: □ Limited a lot □ Limited a little □ Not limited at all

We may have a nurse call you to follow up on your symptoms and check to see how you are doing 3 months from now. Is it okay for us to call you at the number you provided above?

□ Yes □ No