



CERVICAL SPINE INTAKE FORM

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PATIENT INFORMATION

Date: Name: Age: FSO MR #:

CONCERN

(Describe your neck pain, please check all that apply.)

Neck Pain Arm Pain Right Left Bilateral

Date of Injury/Onset of Pain: Auto Accident Work Comp Personal Injury Dates off work:

Work Status: Currently working hrs/wk Severity: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (excrutiating pain)

Not working unemployed retired Status of Pain: Improved No change Worse Resolved

Frequency of Pain: Daily Constant Intermittent Occasional

Location of Pain: Resolved Radiation of Pain: None Weakness: None Numbness/Tingling: None

Table with 4 columns: Location of Pain, Radiation of Pain, Weakness, Numbness/Tingling. Each column has sub-columns for R, L, BL and a list of body parts with checkboxes.

Quality of Pain: Aggravated By: Relieved By: Severe Aching Shooting Dull Resolved Other Lifting Sleeping End of Day Mornings All Activities Other Changing Positions Medication: Sitting Rest Heat Stretching Exercise Other:

Associated Symptoms / Pertinent Negatives: All No Symptoms Improved With: PT Time Injections Meds Other: Symptoms Failed to Improve With: PT Time Injections Meds Other:

Other/Notes:

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:

- Fatigue
- Fever
- Night Sweats

Metabolic/Endocrine:

- Cold Intolerant
- Heat Intolerant

Neurological:

- Difficulty Walking
- Dizziness

Immunological:

- Environmental Allergies
- Food Allergies

Cardiovascular:

- Chest Pain
- Cyanosis (blue coloration of skin)
- Irregular Heartbeats/Palpitations

HEENT:

- Headache
- Vision Loss

Hematologic/Blood:

- Bleeding
- None

Respiratory:

- Cough
- Dyspnea

Integumentary/Skin:

- Rash

Gastrointestinal:

- Constipation
- Diarrhea
- Nausea
- Vomiting

Genitourinary:

- Dysuria
- Hematuria

PATIENT'S MEDICAL CONDITION

Height: ___ft ___in Weight: _____lbs Blood Pressure: _____/_____ List details of any diet program: _____
 My Weight in the last 6 months has: Not Changed Increased _____lbs. Decreased _____lbs.

PATIENT'S MEDICAL HISTORY

(Please check all that apply)

- | | | | | |
|--|---|--|---|---------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Peptic Ulcer Disease | |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Psoriasis | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> PVD | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Depression | <input type="checkbox"/> Juvenile Rheumatoid Arthritis | <input type="checkbox"/> Renal Disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scoliosis | _____ |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> DVT (Blood Clot) | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Seizure Disorder | |
| <input type="checkbox"/> Benigin Prostatic Hyertrophy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sleep Apnea | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> SLE (Lupus) | |
| <input type="checkbox"/> Cerebrovascular Accident (Stroke) | <input type="checkbox"/> GERD | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Spinal Stenosis | _____ |
| <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Gout | <input type="checkbox"/> Obesity | <input type="checkbox"/> Thyroid Disease | |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> None |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | (Heart valve problems) | |

PATIENT'S SURGICAL HISTORY

(Please check all that apply)

- | | | | | |
|--|--|--|--|---------------------------------------|
| <input type="checkbox"/> ACL Surgery | <input type="checkbox"/> CABG | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cardiac (Heart) Valve Replacement | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Small Bowel Resection | _____ |
| <input type="checkbox"/> Angio w/stent | <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Thyroidectomy | |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> LASIK | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Athroscopy (Scope) Details: _____ | <input type="checkbox"/> Cholecystectomy (gallbladder removal) | <input type="checkbox"/> Meniscus Surgery | Gender Specific | |
| | | <input type="checkbox"/> Muscle Biopsy | Female | _____ |
| <input type="checkbox"/> Back Surgery - Details: _____ | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Neck Surgery - Details: _____ | <input type="checkbox"/> Cesarean Section | |
| | <input type="checkbox"/> Colostomy | | <input type="checkbox"/> Hysterectomy | _____ |
| | <input type="checkbox"/> Discectomy | | <input type="checkbox"/> Mastectomy | |
| | <input type="checkbox"/> Gastric Bypass | | Male | _____ |
| | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> ORIF | <input type="checkbox"/> Prostatectomy | |
| | | <input type="checkbox"/> TURP | <input type="checkbox"/> None | |

PATIENT'S FAMILY HISTORY

Is your Father Living? Yes No If no, age deceased _____ cause of death _____
 Is your Mother Living? Yes No If no, age deceased _____ cause of death _____
 Are any of your siblings deceased? Yes No If yes: Brother Sister age deceased _____ cause of death _____
 Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: Yes No Former/Year Quit _____ Consume Alcohol: Yes No Former/Year Quit _____
 History of Substance Abuse: Yes No Age Started: _____ Drug Type(s): _____
 Activity Level: Sedentary Moderate Vigorous Type of Exercise: _____

SIGNATURE

Date: _____ Signature of Patient, Parent or Guardian: _____

