

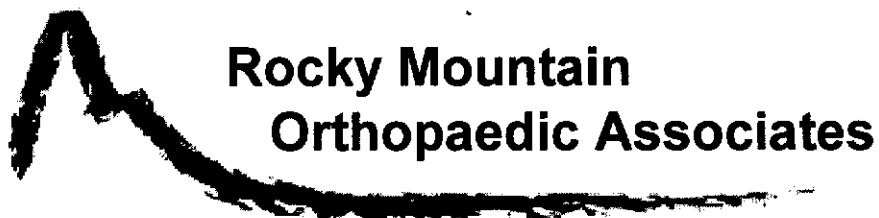
Name:

Chart:

DOB:

Date:

Referring MD:



627 25 ¹/₂ Road • Grand Junction, CO 81505
Phone (970) 242-3535 • 1-800-856-9640

Spine Center

Kirk Clifford, M.D.

Robert Frazho, M.D.

James Gebhard, M.D.

NECK PATIENT QUESTIONNAIRE

- Please answer all questions completely
- It is in your best interest and will assist your doctor with your care

Name: _____

Chart: _____

DOB: _____

Date: _____

Referring MD: _____

A. 1. Referring doctor name and full address: _____

If not, referred, how did you choose this office? _____

2. Internist or family doctor name and address: _____

3. Chief complaint Neck pain Arm: Pain Numbness Weakness Other _____
(check all that apply):

4. Your age: _____ Years _____ Months

5. Your sex: Male Female

6. How long has the pain (or your problem) been present? _____

7. Has your problem worsened recently? No Yes - How recently? _____

8. What started the pain (or problem)? _____

9. Type of pain: Ache Stabbing Throbbing Shooting Burning Click/Pop

10. Pain aggravated by:

- Standing Walking Lying
 Sleeping Working Stairs
 Sitting Driving Cough/Sneeze

11. There is: No loss of bowel or bladder control

Loss of bowel or bladder control

12. I have: Not missed any work because of this problem

Missed (how much) _____ work.

13. Do you enjoy your job? Yes No

14. Is this a work related injury? Yes No

15 a. Is a lawyer or legal consultant involved because of your injury or symptoms? Yes No

15 b. Are you involved in an active lawsuit because of your injury or symptoms? Yes No

16 a. Do you smoke? Yes No

16 b. Do you use chewing tobacco? Yes No

B. 1. What % of your pain is neck pain and what % is arm pain? (check one of the following)

- Neck 0%, Arm 100%
 Neck 10%, Arm 90%
 Neck 25%, Arm 75%
 Neck 50%, Arm 50%
 Neck 75%, Arm 25%
 Neck 90%, Arm 10%
 Neck 100%, Arm 0%

2. What is the distribution of your arm pain? (check one of the following):

- No arm pain
 Right 0%, Left 100%
 Right 10%, Left 90%
 Right 25%, Left 75%
 Right 50%, Left 50%
 Right 75%, Left 25%
 Right 90%, Left 10%
 Right 100%, Left 0%

Name:

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3. Where is your arm pain? (check any of the following that apply):

Right Arm:

Left Arm:

No pain

No pain

Upper back

Upper back

Shoulder

Shoulder

Upper arm

Upper arm

Forearm

Forearm

Hand/finger

Hand/finger

4. Raising the arm: Improves the pain Worsens the pain Does not affect the pain

5. Moving the neck: Improves the pain Worsens the pain Does not affect the pain

6. Do you have weakness in your arms and hands?

No weakness of the arms and hands

I have weakness in the following areas (check any of the following that apply):

Right:

Left:

No weakness

No weakness

Shoulder

Shoulder

Upper arm

Upper arm

Forearm

Forearm

Hand/Finger

Hand/Finger

7. Do you have numbness in your arms and hands?

No numbness of the arms and hands

I have numbness in the following areas (check any of the following that apply):

Right:

Left:

No numbness

No numbness

Upper arm

Upper arm

Forearm

Forearm

Thumb

Thumb

Index finger

Index finger

Long finger

Long finger

Ring finger

Ring finger

Small finger

Small finger

8. Do you have difficulty picking up small objects like coins or buttoning buttons? Yes No

9. Do you have a problems with balance or tripping frequently? Yes No

10. Do you have headaches in the back of the head? Frequent Occasional No

C. Treatments: Please check all treatments you have had for this problem.

Treatments have included: No medicines, therapy, manipulations, injections, or braces

Physical therapy, exercise

Anti-inflammatory medications

Massage & ultrasound

Narcotic medication

Traction

Epidural steroid injections _____times which relieved the pain for (how long)? _____

Manipulation

Trigger point injections _____times which relieved the pain for (how long)? _____

Tens Unit

Shoulder injections

Braces

Other: _____

Name:

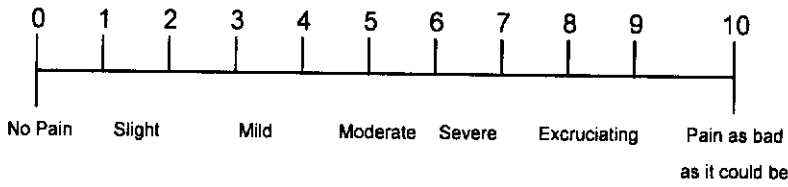
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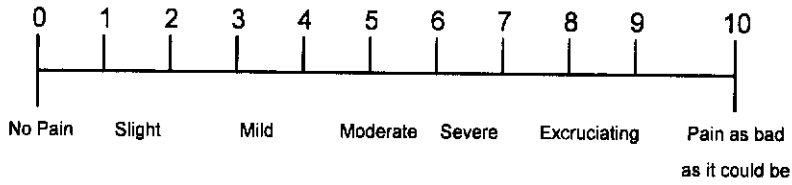
Date:

Referring MD:

MY NECK PAIN IS: (Circle number)



MY ARM PAIN IS: (Circle number)

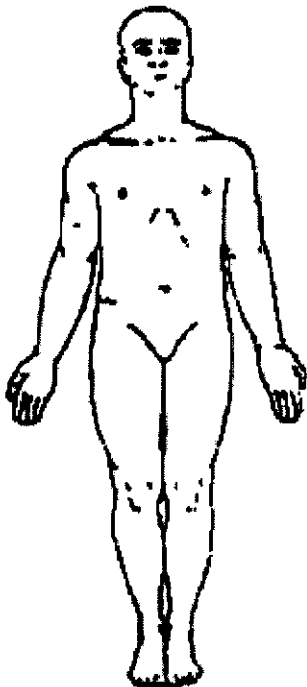


PLEASE INDICATE TYPE AND DISTRIBUTION OF YOUR PAIN ON THE FIGURES BELOW

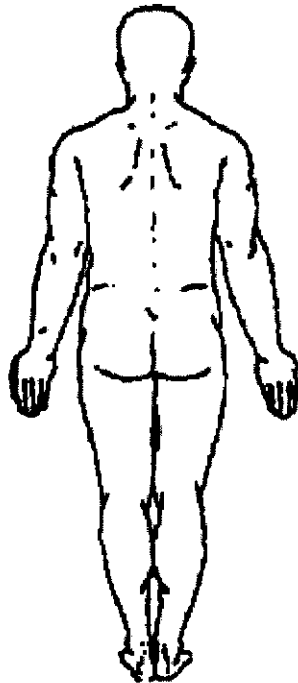
Please use the following key to shade in distribution of pain on figures

Numbness ----- Pins and Needles oooooooooo

Ache xxxxxxxxxxxx Pain //////////////

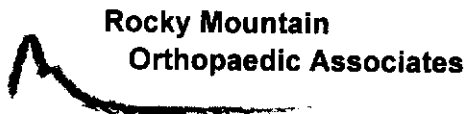


Front



Back

Name:
Chart:
Date:



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- 3 Months
6 Months
Pre-op
12 Months

The Neck Disability Index

Patient Name: TEST, MA File# 1111 Date 10/17/2011

Appt: _____

Please read instructions:

The questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-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.

SECTION 2-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.

SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4-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 to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability, 30-48% is moderate, 50-68% is severe; 72% or more is complete.

SECTION 6-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 in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7-WORK

- I can do as much work as I want to.
- I can 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 can't do any work at all.

SECTION 8-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 can't 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 can't drive my car at all.

SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.