



Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

Right handed or left handed (circle one)

Referred by \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

Reason for Visit \_\_\_\_\_

### CURRENT SYMPTOMS

1. Where is your pain?

Right Arm	Left Arm	Right Leg	Left Leg
Does it involve your neck:			No Yes
Does it involve your back/trunk:			No Yes

2. When did your pain begin? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

3. What are your symptoms: Pain Numbness/Tingling Weakness

4. Is your pain: Constant? Intermittent? Occasional?

5. Is your pain: Severe? Moderate? Mild?

6. Over time has your pain become : Worse Better Same

7. Has it changed recently? \_\_\_\_\_

8. What position/activity makes the pain worse/better?

#### Worse Better

Sitting

Standing

Walking

Use of shopping cart

9. How far can you walk without symptoms:

Less than one block

1-3 blocks

No limitations

10. Do you have an MRI and /or CT Scan? When? \_\_\_\_\_

Where? \_\_\_\_\_

11. Do you have other symptoms with your pain?

Numbness/Tingling? No Yes Where? \_\_\_\_\_

Cramps/Spasms? No Yes Where? \_\_\_\_\_

Weakness? No Yes Where? \_\_\_\_\_

Problems with balance? No Yes

## HISTORY

Did your symptoms begin after an injury (i.e. a car accident or fall)? No Yes

Date of injury \_\_\_\_\_ Type of injury \_\_\_\_\_

Did the injury occur at work or is it work related? No Yes

Who was your employer on the date of injury? \_\_\_\_\_

Did you have any previous or prior injury to your neck or back before the injury mentioned above? No Yes

Date \_\_\_\_\_ Location \_\_\_\_\_

Describe injury \_\_\_\_\_

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## CURRENT TREATMENT: Have you tried the following:

1. Physical Therapy No Yes

2. Anti-inflammatories No Yes

3. Injections No Yes

## VISUAL ANALOG SCALE

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### NECK AND ARMS

Please rate your **neck** pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10  
(no pain) (worst pain imaginable)

Please rate your **right arm** pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10  
(no pain) (worst pain imaginable)

