DISC CENTERS of AMERICA™ CENTRAL FLA.

NON-SURGICAL SPINAL DECOMPRESSION

NECK

Name: _____ **Date Of Birth:** _____ **Date Of Appointment:** _____

Age: _____ **Right or Left-Handed:** _____ **Sex:** _____

Occupation/Profession: _____

Date Of Injury (if appropriate): _____

Description of Injury (if appropriate): _____

How Long have you had neck pain?_____

What does your pain feel like? Sharp Stabbing Dull Aching Burning Throbbing
(circle all that apply)

How frequently are you experiencing this pain? Constantly Multiple Times A Day Once A Day 1-2 Times per Week
(circle only one)

Where is the pain located? Center of Spine Left of Center Right of Center Left, Right, & Center of Spine
(circle only one)

Does numbness, tingling, or pain run down the arm? (circle only one) Not at All Constantly Daily 1-2+ Times Per Week

If yes:

Which side does the numbness, tingling, or pain run down? Right Left Both

Does the numbness, tingling, or pain reach the level of your shoulders? No Yes

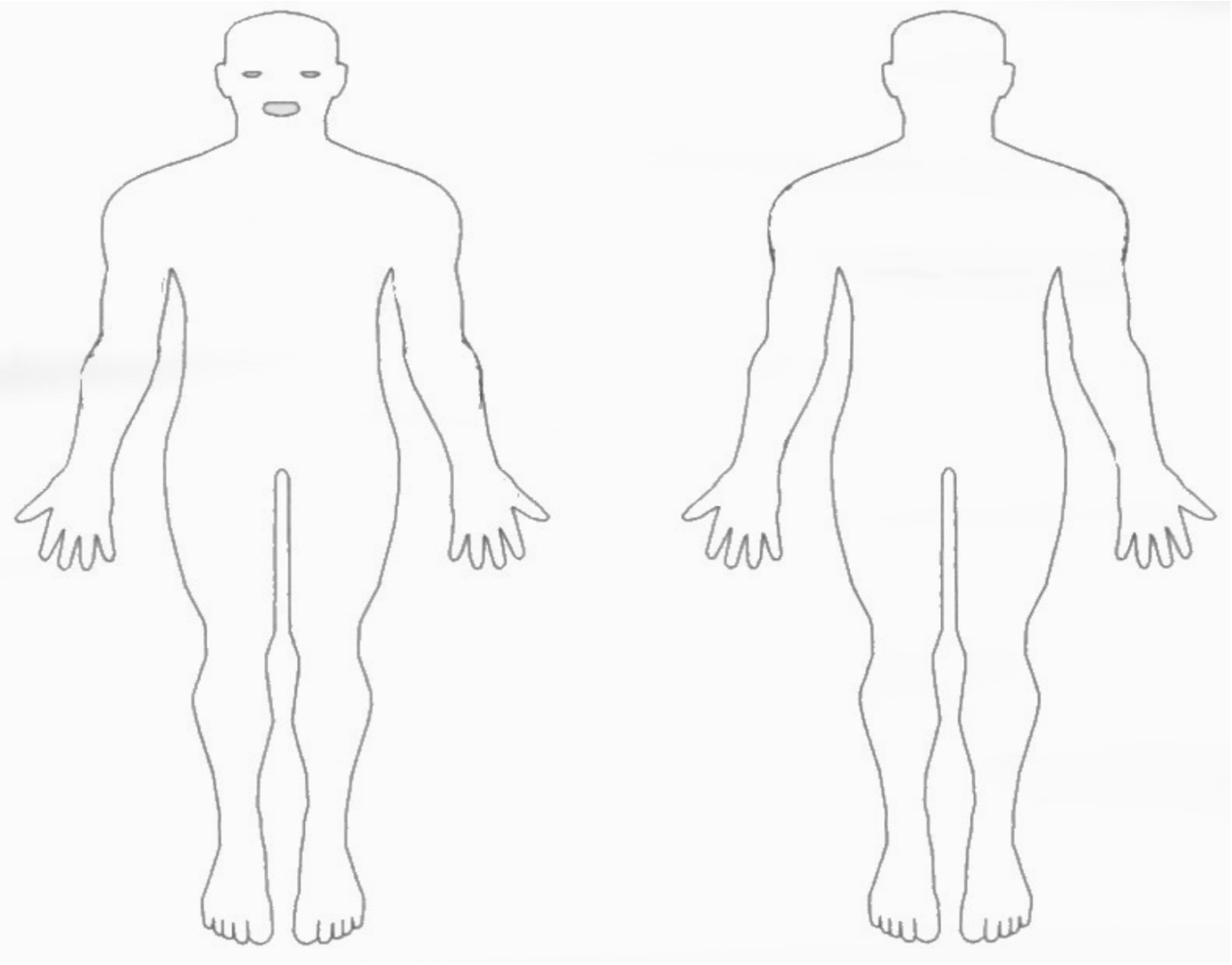
Does the numbness, tingling, or pain reach your elbows? No Yes

Does the numbness, tingling, or pain reach your fingers? No Yes

If yes, circle which finger(s) are involved: Thumb Index Middle Ring Small

Which is more severe? Pain in my neck Pain in my upper back/ Shoulders Pain in my arms Pain in my hands

If you have extremity numbness, tingling, or pain, color in which areas are affected:



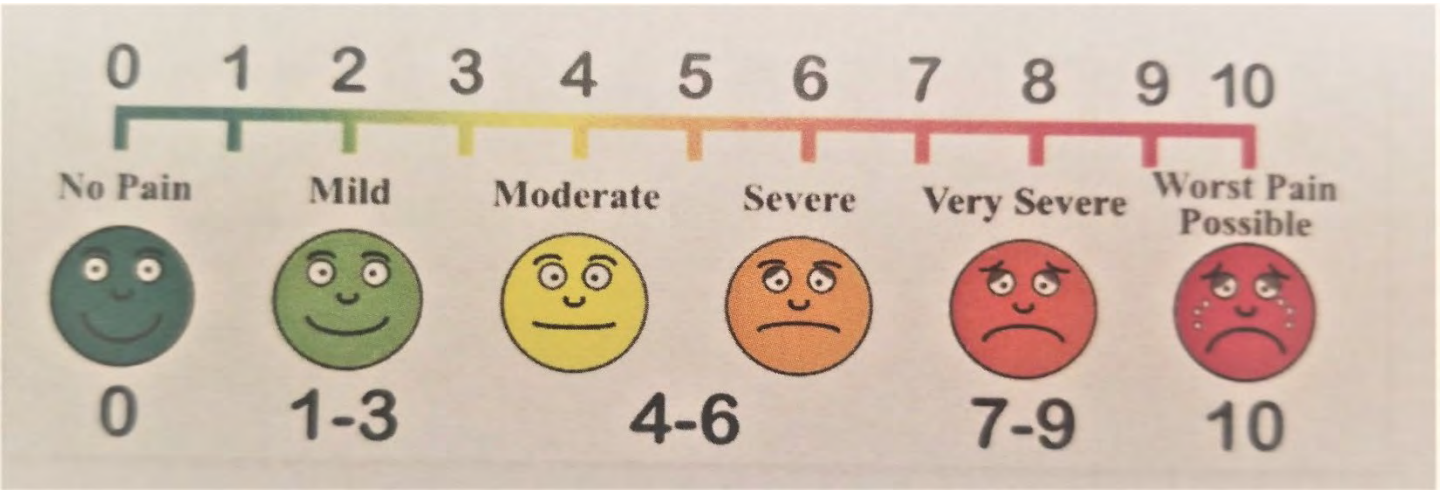
Are you experiencing weakness in the arms? No Yes, both Yes, the right Yes, the left

If yes, how do you notice the weakness?
(circle all that apply)

Entire limb(s) feel weak or heavy	Difficulty lifting objects due to shoulder weakness	Difficulty lifting objects due to elbow weakness
My wrist(s) feel weak	Decreased grip strength	Decreased finger strength
I'm dropping objects	Difficulty opening jars	

How severe is your pain on a scale from 0 to 10? (Use the scale below to help guide you)

At its best _____ At its worst _____ Average or Usual _____



What things make your pain worse?

Prolonged sitting	Lifting my head upwards	Stress/tension
Prolonged standing	Looking downwards	Lifting Kids/Bags/Suitcases
Sneezing/coughing	Turning my head side to side	Pushing objects
Any activity with my hands/arms		

Other: _____

What things make your pain better?
(circle all that apply)

No Movement	Stretching	Heat	Medication
Changing Physical Positions	Ice/Cold	Massage	Rest
Braces	Neck traction		

Other: _____

Are you having accidents of bowel or bladder?
(circle one)

No Yes, Bowel Yes, Bladder Yes, Both Bowel and Bladder

Are you having headaches from your neck pain?
(choose one)

No	Yes, constantly	Yes, multiple times a day	Yes, roughly every other day	Yes, at least twice a week
Yes, at least once a week	Yes, a few times a month	Yes, at least once a month		

I have had previous treatment consisting of:

Physical therapy	Chiropractic Manipulations	Epidural Steroids
Massage	Surgery	Acupuncture

Previous medications I have tried for this condition:

No Medications	Anti-inflammatory	Opioid	Steroid Dose-pak	Muscle Relaxants
Nerve Medications Like Gabapentin or Lyrica		Mild Pain-reliever Like Tylenol		

What is the maximum weight you can tolerate lifting without provoking pain? _____lbs
(One gallon of water weighs 8 lbs.)

Habits:

Smoke tobacco:

Yes or No. If yes, packs /day? ____, how many years? ____, Quit? (Yes or No) When?_____.

Drink Coffee / caffeine:

No__/Yes__, how many cups/mugs/cans a day_____.

Drink Alcohol:

No__/Yes__. How many glasses liquor or beers a day____ week____.

Drug Use :

No__/Yes___, Are you in a methadone program? No__/Yes__

Detail type of substance and frequency_____

Medications You Are Taking In General:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies To Medications: _____

_____

Have you had a history of the following:

____Yes ____No Glaucoma
____Yes ____No Diabetes
____Yes ____No Thyroid Disease
____Yes ____No High blood pressure
____Yes ____No Lung Disease
____Yes ____No Heart disease
____Yes ____No Stomach ulcer
____Yes ____No Recent infections
____Yes ____No Cancer (type) _____
____Yes ____No HIV Positive (AIDS)
____Yes ____No Hepatitis B
____Yes ____No Bleeding or blood clots
____Yes ____No Neck or Back pain
____Yes ____No Syphilis
____Yes ____No Arthritis
____Yes ____No Osteoporosis/Osteopenia
____Yes ____No Rheumatoid arthritis
____Yes ____No Spina Bifida

Has any member of your family had a history of the following:

____Yes ___ No Glaucoma
____Yes ____No Diabetes
____Yes ____No Thyroid Disease
____Yes ____No High blood pressure
____Yes ____No Lung disease
____Yes ____No Heart disease
____Yes ____No Stomach ulcer
____Yes ____No Recent infections
____Yes ____No Cancer (type)_____

Any other medical problems? _____

Functional History:

Check ('x") if you have a problem;

( ) Walking: independent___, use a cane___/brace____ .
( ) Climbing: upstairs independent?
( ) Driving: Independent?
( ) Transfers (get up, bed to chair, sitting to standing).
( ) Dressing oneself (shirt, pants, shoelaces).
( ) Eating/ drinking (cooking).
( ) Self care (urinating, defecating,) and personal.
( ) Hygiene (bathing, brushing, combing, etc.).

Social History:

I live in a House /Apartment / Other_____
How many steps/stairs to your room?_____
Do you live alone? Yes__ / No__, with whom?_____
If you have a home attendant, #hours/day_____/_____

Functional Work Demands:

Current occupation_____
Primary activities you do at work: Sitting ( ), standing ( ), kneeling ( ), bending forward ( )
bending backward ( ) rotating the trunk ( ) squatting ( ) reaching ( )
How many required hours spent sitting? _____
How many required hours spent driving? _____
How many required hours using the computer? _____
How many required hours standing? _____
How much weight is required that you lift? _____

Recreational History:

Practice Sports or exercise? No__ /Yes__. If yes, how many times a week?_____
What kind of sports? _____

I enjoy (movies/ theater / listening to music /dancing, racing, etc) _____
_____

REVIEW OF SYSTEMS:

Please CHECK each that applies to you.

GENERAL:

□yes □no Unexplained changes in weight
□yes □no Fever, Chills, Night sweats

NEUROLOGICAL:

□yes □no Unusual change in voice
□yes □no Seizures
□yes □no Loss of consciousness
□yes □no Memory difficulties
□yes □no Disorientation
□yes □no Difficulty with speaking
□yes □no Difficulty with writing
□yes □no Difficulty with reading
□yes □no Dysphagia
□yes □no Double vision
□yes □no Loss of vision
□yes □no Tremors
□yes □no Difficulty walking
□yes □no Weakness
□yes □no Numbness
□yes □no Changes in sensation
□yes □no Tingling
□yes □no Bleeding gums

HEAD:

□yes □no Headache
□yes □no History of head contusions
□yes □no Hearing
□yes □no Auditory problems
□yes □no Dizziness
□yes □no Ear buzzing
□yes □no Sinus (stuffy nose)
□yes □no Ear pain
□yes □no Dental problems
□yes □no Metal implants

CARDIOLOGY/PULMONARY:

□yes □no Chest pain
□yes □no Palpitations
□yes □no Murmur
□yes □no Swollen feet legs worse end of the day
□yes □no Cough
□yes □no Wheezing
□yes □no Shortness of breath walking up one-flight of stairs.

GASTROINTESTINAL:

□yes □no Digestion problems
□yes □no Bloating
□yes □no Nausea
□yes □no Heartburns
□yes □no Vomiting
□yes □no Constipation
□yes □no Unexplained diarrheas
□yes □no Abdominal pain
□yes □no Sour mouth sensation after sleeping.

GENITAL/URINARY:

□yes □no Difficulty urinating
□yes □no Urge urinating
□yes □no Pain urinating
□yes □no Painful intercourse
□yes □no Vaginal secretions
□yes □no Bladder incontinence
□yes □no Kidney stones
□yes □no Kidney infections

MUSCULAR/SKELETAL:

□yes □no Diffuse muscle aching
□yes □no Fibromyalgia
□yes □no Legs or joint swelling
□yes □no Stiffness
□yes □no Painful foot sole or arch "*first steps in the morning*".

SKIN/HAIR:

□yes □no Changes in skin moles
□yes □no Non-healing ulcers
□yes □no Dry skin
□yes □no Itching
□yes □no Nail fungus

ENDOCRINE/HEMATOLOGICAL/ IMMUNE:

□yes □no HIV positive
□yes □no Hepatitis
□yes □no Fainting
□yes □no Swollen armpit
□yes □no Swollen groin glands,
□yes □no Pale color
□yes □no Bleeding disorders
□yes □no Recurrent infections

Recent Imaging Studies Within The Past Year: (check all that apply)

X-rays of my neck ☐ when:_____ where: _____

CTs of my neck ☐ when:_____ where: _____

MRIs of my neck ☐ when:_____ where: _____

Myelogram of my neck ☐ when:_____ where: _____

Physicians I have seen for my neck problem:

(fill in applicable information)

	Name	Phone Number	City Located In
Primary care provider:	_____	_____	_____
Chiropractor:	_____	_____	_____
Neurologist:	_____	_____	_____
Pain Medicine Specialist:	_____	_____	_____
Orthopedic Surgeon:	_____	_____	_____
Neurosurgeon:	_____	_____	_____

_____