



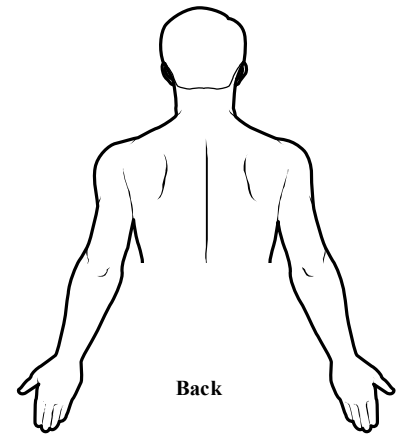
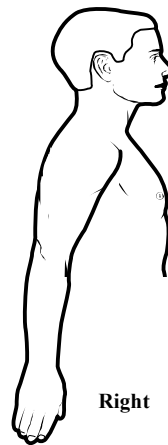
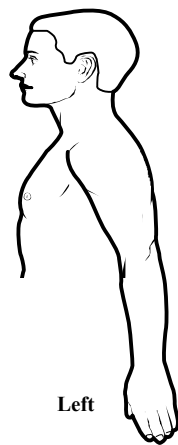
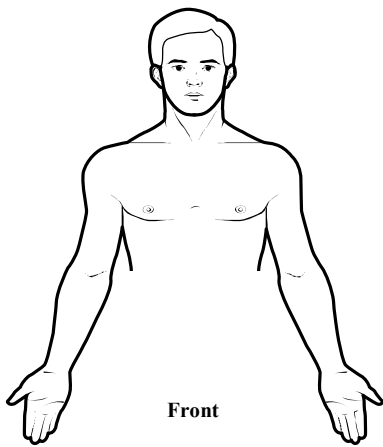
SPURLOCK SPINE CENTRE

Head/Neck/Arm Complaints

Today's Date: ____ / ____ / ____ Name: _____

Circle the areas on your body where you feel the described sensations. Use the appropriate letter(s) and include all affected areas.

| | | | | | |
|-----------|--------------|-------------|-----------------|------------------|-------------|
| Ache-A | Cramping-C | Dull Pain-D | Pins/Needles-Pn | Shooting Pain-Sh | Soreness-So |
| Burning-B | Deep Pain-De | Numbness-N | Sharp Pain-S | Stabbing Pain-St | Throbbing-T |



Quality

- Do you experience arm or leg weakness? No Yes, where _____
- Do you have a fever? No Yes Not sure
- Do your symptoms INCREASE with a cough/sneeze or straining with a bowel movement? No Yes
- Do you have any *new* difficulties since this condition began with: **bowel** No Yes; **bladder** No Yes; **sexual functions**; No Yes; (describe): _____
- Describe how your pain has changed recently. (Check only ONE statement)
 Remained about the same Feeling better Feeling worse Erratic
- Similar or recurrent condition? No previous episodes Recurrent problem (for how long): _____
 Similar problem (describe and occurred when): _____
- Pain Scale and Quality: List any other symptoms you are experiencing in this region (In addition to the drawing)
 Electrical Shock Tightness Lancing Pain Vague Discomfort Pops/Cracks
 Stiffness Other, (describe): _____
- Please circle the number which best describes your pain level, or if the pain varies, list a range (0-No Pain and 10-Worst Pain you can imagine): 0 1 2 3 4 5 6 7 8 9 10 or Range: _____

Frequency

- How frequent does your condition occur? Intermittent (0-25%) Occasional (26-50%) Frequent (51-75%)
 Constant (76-100%) Times per week: _____ Times per month: _____ Times per year: _____

Duration

10.) How long have you had this current episode or condition? _____

Timing

11.) Describe what caused your problem (if known) and how the problem has progressed: _____

12.) Palliative: What activities or positions **REDUCE** your pain?

- Nothing Bending Neck Backward Heating Pad Raising Arms Up Resting
- Any Movement Cervical Collar Hot Bath/Shower Sitting Turning Head
- Bending Neck Forward Cold Packs Lying on Back Standing
- Other, describe: _____

13.) Provocative: What activities or positions **INCREASE** your pain?

- Nothing Bending Neck Backward Extremes of Movement Lifting Standing
- Any Movement Cervical Collar Heating Pad Lying on Back Turning Head
- Bending Neck Forward Cold Packs Hot Bath/Shower Sitting
- Other, describe: _____

14.) Is your condition worse? Morning Later in Day End of Day At Night No Pattern

Previous Treatment

15.) Previous treatment for this condition: None

Treatment which IMPROVED this condition: _____

Treatment which did NOT IMPROVE this condition: _____

Length of treatment for each type of treatment: _____

List Hospital(s), Doctor(s), therapist(s) and the year seen: _____

List tests performed, where performed, and year (x-rays, MRI, CT scan, bone scan, EMG/NCV, etc): _____

Functional Capacity

16.) Functional limitations due to pain: How many pounds can you lift? _____ How long can you stand? _____
How long can you sit? _____ How long can you walk? _____

17.) Have you been totally disabled from your work? No Yes; or home-maker duties? No Yes
How long? _____

18.) Have you been partially disabled from your work? No Yes; or home-maker duties? No Yes
How long? _____