

MR #: _____

Name: _____

CONFIDENTIAL CERVICOTHORACIC PATIENT QUESTIONNAIRE

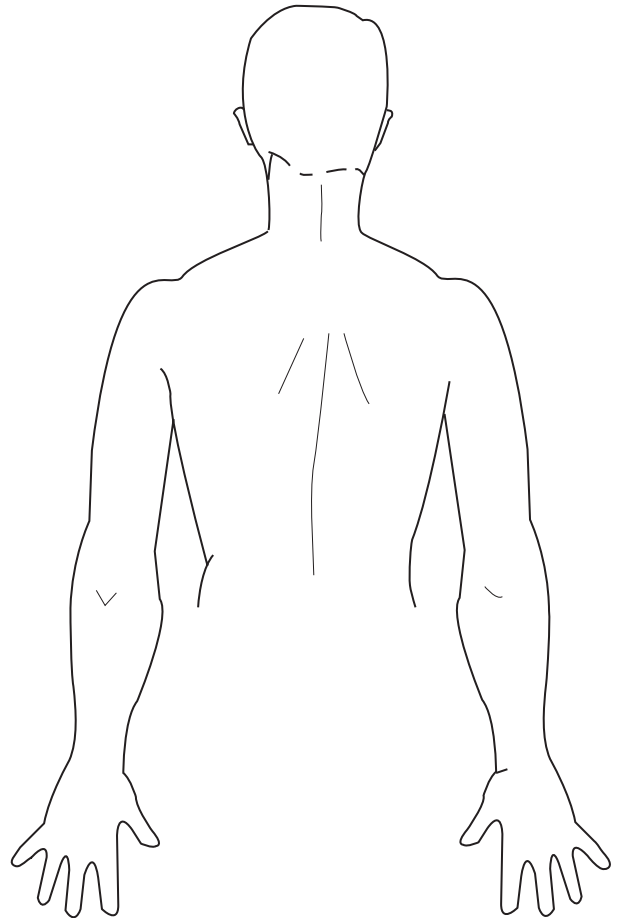
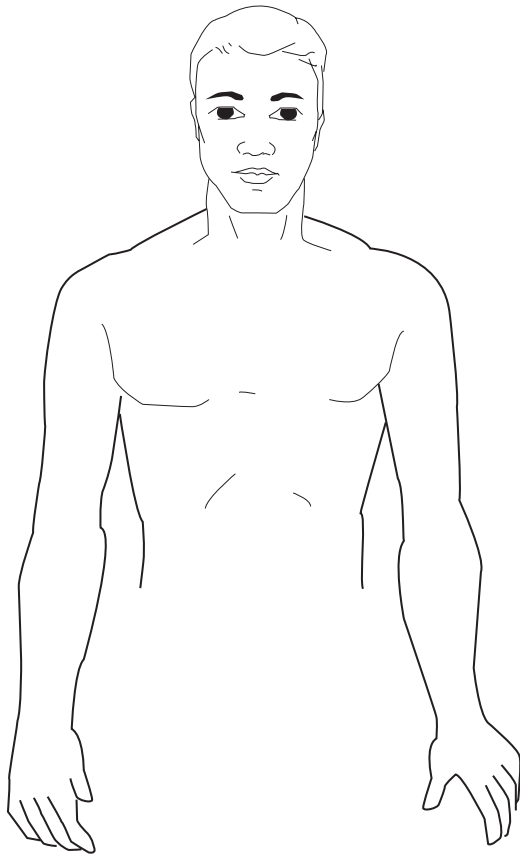
IMPRINT AREA

PAIN DIAGRAM – Please answer each question

Please place X's on the diagram below where you are experiencing pain or numbness.

FRONT

BACK



Right

Left

Left

Right

My primary pain is in my: **(Check only one)**

- Neck / Upper Back Shoulder / Arm Forearm / Wrist Hand

What percentage of your pain is in your neck / upper back? _____%

What percentage of your pain is in your shoulder / arm / forearm / wrist? _____%

(Must equal 100%)

On a scale of 0 to 10, with zero being no pain and 10 being excruciating pain, I would rate my pain **today** as:

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, with zero being no pain and 10 being excruciating pain, I would rate my pain **over the past two weeks** as:

0 1 2 3 4 5 6 7 8 9 10

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PATIENT QUESTIONNAIRE – Continued**

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DEMOGRAPHIC DATA

NAME		KAISER MR #	
AGE	SEX	HEIGHT	WEIGHT

Dominant hand: Left Right

How long have you been a Kaiser Permanente member? Years Months Weeks

Kaiser Permanente Personal Provider: _____

Referring Provider: _____

Did your referring provider explain the purpose of today's visit? Yes No

How many providers have you consulted for today's problem? 1 or 2 2-4 4-6 >6

Have you seen any non Kaiser Permanente provider for today's problem? Yes No

Did you receive information pertaining to today's visit in the mail? Yes No

HISTORY

My chief complaint is: _____

This has been going on for: _____ Days _____ Weeks _____ Months _____ Years

Do you have ideas or opinions on what caused your current problem? _____

If your current problem stems from a specific injury, please describe the nature and date of the incident or accident: _____

Are there any activities or positions that seem to aggravate your pain? (Explain): _____

Are there any activities or positions that seem to make your pain better? (Explain): _____

FUNCTIONAL LIMITATIONS

My pain is worse: Morning Midday Night After exercise

Please describe the location of any weakness that you experience:

Neck Shoulder Arm Forearm Wrist / Hand

Please describe the location of any numbness that you experience:

Neck Shoulder Arm Forearm Wrist / Hand

Do you experience any difficulty using your hands for writing, buttoning your buttons, picking up small objects, or feeling change in your pockets? Yes No

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RED FLAGS

Do you have a history of heart disease? Yes No

Do you have a history of high blood pressure? Yes No

Do you experience chest pain? Yes No

Do you have diabetes? Yes No

Do you experience incontinence? (Loss of bladder or bowel control) Yes No

Do you experience difficulty with balance or walking? Yes No

Have you experienced any recent unintended weight loss? Yes No

If you answered yes to the previous question, please describe how much weight you have lost and over what time frame: _____

Have you experienced any recent fevers, chills, or night sweats? Yes No

Do you have a history of cancer of any sort? Yes No

If you answered yes to the previous question, please describe the type of cancer and the date of diagnosis: _____

THERAPIES TRIED

What have you tried for your symptoms? (Check all that apply)

- | | | | | |
|---|---------------------------------------|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Neck Class | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Herbs | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Feldenkrais | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Epidural Steroids | <input type="checkbox"/> TENS Unit |
| <input type="checkbox"/> Oral Medicines | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Massage | <input type="checkbox"/> Chronic Pain Program | <input type="checkbox"/> Pilates |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Braces | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Surgery | <input type="checkbox"/> Other |

If you checked "Other", please describe: _____

Are there any other treatments that you are aware of that you would like to try for your current problem? (List): _____

OCCUPATIONAL / LIABILITY – Please answer each question

Is today's problem related to an on-the-job injury? Yes No Unsure

If you answered yes or unsure to the above question, please describe the date and circumstances of your on-the-job injury: _____

Have you been treated for today's problem in an

Occupational Medicine clinic? Yes No

Have you filed a claim for today's problem with your employer? Yes No

Is today's problem related to a personal injury case or

motor vehicle accident? Yes No Unsure

If you answered yes or unsure to the above question, please describe the date and nature of your personal injury or motor vehicle accident: _____

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OCCUPATIONAL / LIABILITY – Continued

Do you have or anticipate litigation (law suit) regarding today's problem? Yes No Unsure

If you answered yes or unsure to the above question, please list the name of your attorney or law firm below: _____

PAST MEDICAL HISTORY

Please list all of your medical problems: _____

Please list any psychiatric or psychological problems that you have experienced: _____

Please list all surgeries that you have undergone along with their dates: _____

FAMILY HISTORY

Are there any medical problems that run in your family? (List): _____

MEDICATIONS

Please list your current medications: _____

Please list any herbs or over-the-counter medications that you are currently using: _____

ALLERGIES

Please list any allergies to medicine or foods that you experience: _____

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HABITS

Do you **smoke**? If so, how much and for how long? _____

Do you currently drink **alcohol** or have a history of doing so? If so, please explain how much and for how long: _____

Do you currently use any **recreational drugs** or have a history of doing so? Please explain: _____

SOCIAL HISTORY

What is your marital status?

- Married / Living with spouse Single / Never married Divorced Separated
 Widowed Living with a significant other Living with a domestic partner

What is your level of education?

- Grammar School High School Diploma GED Some College
 College Degree Professional School Masters / PhD Trade School

WORK HISTORY

What is your current employment status?

- Currently Working Full-Time Currently Working Part-Time On Light Duty
 Unemployed Full Time Student Part Time Student
 Homemaker Retired Retired Due to Disability
 On Sick Leave In Vocational Rehabilitation

If you are retired or on sick leave due to a disability, please list the nature of the disability and date of your retirement / sick leave: _____

What line of work are you currently in or retired from? _____

If you are working, how long have you worked at your current job? _____

Do you enjoy your job? _____

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REVIEW OF SYSTEMS

In addition to your spine problems do you have any of the following: *Check all that apply*

General:

Fevers, chills, night sweats, nausea, vomiting, lethargy, fatigue, recent unexplained weight loss

Skin / Breasts:

Rashes, lumps under the skin, swollen lymph nodes, nipple discharge

Cardiovascular:

Chest pain, left arm or jaw pain, skipped or irregular heart beats, heart murmur, fast or slow heart beats, chest tightness or pressure, swollen extremities

Endocrine:

Hot or cold intolerance, frequent urination, brittle bones

Eyes/Ears/Nose/Mouth/Throat:

Sore throat, sores in mouth, difficulty swallowing or getting food down, swollen lymph nodes

Genitourinary:

Trouble with urination, dribbling, difficulty with starting a stream, frequent urinary tract infections, kidney stones, burning with urination, cloudy urine, pelvic pain

Gastrointestinal:

Bloating, abdominal pain, history of irritable bowel syndrome, pain after eating, trouble with bowel movements, blood in stool, constipation, diarrhea

Hematological:

Easy bleeding or bruising, bleeding with a tooth brush

Musculoskeletal:

Pain in the joints, muscle pains, limitation of range of motion, muscle cramping, diffuse muscle tenderness

Neurological:

Seizures, headaches, migraines, vision problems, problems with swallowing, problems with coordination, difficulty using your hands, difficulty walking, frequent falls, memory loss, shuffling gait, slurred speech

Psychiatric:

Anxiety, stress, post-traumatic stress disorder, depression, bipolar, panic attacks, mania, trouble controlling mood, history of alcohol or drug dependence, sleep disturbance, history of emotional abuse, history of physical abuse, history of sexual abuse, drug or alcohol addiction

Respiratory:

Trouble breathing, frequent coughing, production of sputum, blood in sputum, shortness of breath, difficulty in sleeping on your back, shortness of breath when sleeping, snoring

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Please indicate with an X in the box the answer that best describes how you have been feeling recently.

<i>PLEASE ANSWER EVERY QUESTION.</i>	Rarely or none of the time	Some of the time (1-2 days a week)	Good part of the time (3-4 days a week)	Most of the time (5-7 days a week)
1. I feel downhearted and sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Morning is when I feel the best.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have crying spells or feel like it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have trouble sleeping at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I feel that nobody cares.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I eat as much as I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I still enjoy sex.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I notice that I am losing weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I have troubles with constipation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My heart beats faster than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I get tired for no reason.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. My mind is as clear as it used to be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I tend to wake up too early.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I find it easy to do the things I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I am restless and can't keep still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I feel hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am more irritable than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I find it easy to make decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I feel quite guilty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I feel that I am useful and needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. My life is pretty full.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I feel that others would be better off if I were dead.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I still enjoy the things I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Please indicate how you have felt during the PAST WEEK by making an X in the appropriate box.

PLEASE ANSWER EVERY QUESTION.

**Do not think too long
before answering.**

	Not at all	Slightly, a little	A great deal	Extremely, could not have been worse
1. Heart rate increase.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling hot all over.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sweating all over.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sweating in a particular part of body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pulse in neck.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Pounding in head.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dizziness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Blurring of vision.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Feeling faint.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Everything appearing unreal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Nausea.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Butterflies in stomach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Pain or ache in stomach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Stomach churning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Desire to pass water.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Mouth becoming dry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Difficulty swallowing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Muscles in neck aching.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Legs feeling weak.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Muscles twitching or jumping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Tense feeling across forehead.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Tense feeling in jaw muscles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have answered each question to the best of my ability.

Signature: _____ **Date:** _____