PATIENT QUESTIONNAIRE FOR CERVICAL SPINAL CONDITIONS

It is important that each question be answered as fully as possible. Incomplete answers may result in denial of some of your treatment options by your insurance company.

SYMPTOMS:

1. How long have you experienced neck pain? ____

2. Does your pain radiate into one or more of your upper extremities? (arms, hands, fingers) ___yes ___no
   If yes, right, left or both? ____

3. Are you experiencing weakness in your upper extremities? ___yes___no
   If yes, please indicate right, left, or both ____

4. Are you experiencing any lack of bladder control? ___yes___no

5. Are you experiencing any change in your ability to walk? ___yes___no

6. Does your neck pain come and go or is it constant?____

HISTORY:

1. Is your pain level affecting your lifestyle / ability to perform daily living activities? ___yes___no
   If yes, please explain:____
   ____

2. What lifestyle adjustments / therapies have you undertaken to help you in the performance of your daily living activities? Please check each that you have tried and indicate how long:

   _____ Anti-inflammatory medications: ___3___6___12 months___longer
   _____ Pain medications: ___3___6___12 months___longer
   _____ Daily exercise (specifically for neck problem: ___3___6___12 months___longer
   _____ Activity / lifestyle modification (such as rest, avoiding activities that aggravate your symptoms, etc.):
   ___3___6___12 months___longer
   _____ Weight reduction: ___yes___no___not significantly overweight
   _____ Supervised Physical Therapy program completed: ___yes___no If yes, how long?
   ___3___6___12 months___longer
   _____ Localized injections, such as trigger-point or epidural injections: ___yes___no If yes, for how long?
   ___3___6___12 months___longer
   _____ Other; please describe: ____
   ____

3. Do you currently smoke cigarettes? ___yes___no
   ***NOTE* Patients who smoke are hereby advised to stop at least 6 weeks before a planned surgery involving spinal fusions. Studies have demonstrated that the rate of non-fusion in smokers is as much as twice that of non-smokers due to the negative effects of nicotine on bone growth.**

______________________________________ ______________________

PATIENT NAME DATE COMPLETED

4. Have you had a prior neck surgery? ___yes___no If yes, when? ______________________________
   If yes, did you have some relief of symptoms following surgery? ___yes___no

5. Have you previously been under the care of a physician for your cervical condition? ___yes___no If yes, Please summarize approximately when, for how long, and what type of treatment you received: ________
   ____
   ____
   ____
   ____
   ____

6. If you have undergone conservative (non-surgical) treatment for your neck condition (such as physical therapy, treatment by pain management specialist, injections, chiropractic, etc.), by whom were you treated and when?

   _______________________________________ From: _____________ To: _____________
   _______________________________________ From: _____________ To: _____________
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PATIENT NAME DATE COMPLETED