Cervical Spine Intake Survey

SUBJECTIVE HISTORY
1. What is your date of injury/onset of symptoms? ________________________________
2. How did you injure yourself? ________________________________
3. Have you had any of the following?
   □ X-Rays    □ CT Scan   □ MRI    □ EMG/Nerve Conduction Test    □ Other ____________
4. Have you had any prior occurrences of this condition?  □ Yes  □ No
   If yes, explain: ____________________________________________
5. Have you had any prior treatments/surgeries for this injury/condition?  □ Yes  □ No
   If yes, explain: ____________________________________________
6. Due to your physical ailment, do you feel a need for or want a social worker to contact you?  □ Yes  □ No

CURRENT COMPLAINT
7. What is your chief complaint? ____________________________________________
8. What makes your pain BETTER? ____________________________________________
9. What makes your pain WORSE? ____________________________________________

PAIN SCALE
10. If you have pain, what is your pain level? 0= No Pain, 10= Extreme pain
    Please circle number for each:
    CURRENT Pain Level: 0 1 2 3 4 5 6 7 8 9 10
    Pain level at BEST: 0 1 2 3 4 5 6 7 8 9 10
    Pain level at WORST: 0 1 2 3 4 5 6 7 8 9 10

   Mark the location of your pain with "X"

MEDICAL HISTORY
11. Complete your medical history below by checking the appropriate box
   □ Allergies    □ Heart Disease    □ Refer to EPIC EMR
   □ Anemia    □ Heart Palpitations    □ Physical Abnormalities
   □ Asthma    □ Heat/Cold Intolerance    □ Polio
   □ Bladder/Bowel Abnormalities    □ Hernia    □ Pregnancy (current)
   □ Cancer    □ High Blood Pressure    □ Recent Fractures
   □ Chest Pain/Angina    □ Hypoglycemia    □ Rheumatoid Arthritis
   □ Depression    □ Kidney Problems    □ Ringing of Ears
   □ Diabetes I/II    □ Liver Problems    □ Seizures/Epilepsy
   □ Dizziness/Fainting    □ Metal Implants    □ Sexual Dysfunction
   □ Fever    □ Nausea/Vomiting    □ Skin Abnormalities
   □ Fibromyalgia    □ Night Pain    □ Smoking History
   □ Gallbladder Problems    □ Osteoarthritis    □ Stroke/TIA
   □ Headaches    □ Osteoporosis    □ Surgeries
   □ Heart Attack    □ Pacemaker    □ Urine Leakage
   □ Other ____________

12. Is there any other information regarding your medical history that we should know about?

__________________________________________
13. Do you live:  □ Alone  □ With Spouse  □ With Family  □ Other ____________
14. Do you have stairs?  □ Yes  □ No  If yes, how many? ______________
   Do you have a handrail?  □ Yes  □ No
15. How are your interests/hobbies affected by your symptoms? ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________

MEDICATIONS
16. Please list all of the medications that you are currently taking: ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________

MEDICAL PRECAUTION/CONTRAINDICATIONS
17. Are there any factors that may complicate your ability to participate in therapy?  □ Yes  □ No
   If YES, please explain: ______________________________________
18. Have you fallen in the past 12 months?  □ Yes  □ No  If YES, how many times? ______
19. If YES, please describe the nature of the fall(s) and if any injury occurred: ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________

OCCUPATION/WORK STATUS
20. What is your occupation? ______________________________________
21. Are you presently working?  □ Yes  □ No
   If Yes, what is your status:  □ Full Duty  □ Limited Duty  Explain: ______________________________________
22. Are you now or ever have been disabled (service at work)?  □ Yes  □ No
   If YES, when? ______________________________________

LEVEL OF FUNCTION
23. How were you functioning on a daily basis prior to your injury/illness? ______________________________________
   ______________________________________
   ______________________________________
24. How often have you completed at least 20 minutes of exercise (jogging/cycling/brisk walking) prior to the onset of your condition?
   □ ≥3 Times/Week  □ 1-2 Times/Week  □ Seldom  □ Never

STATEMENT OF SELF-RELATED HEALTH
25. How would you classify your general health?  □ Good  □ Fair  □ Poor

PHYSICAL THERAPY PATIENT GOALS
26. What are your goals for participating in therapy? ______________________________________
   ______________________________________
   ______________________________________

27. This is a statement other patients have made. "I should not do physical activities which (might) make my pain worse." Please rate your level of agreement with this statement below.
   □ Completely Disagree
   □ Somewhat Disagree
   □ Unsure
   □ Somewhat Agree
   □ Completely Agree
FUNCTIONAL/ADL ABILITY RESTRICTIONS

IF YOU HAVE **MEDICARE**, PLEASE ANSWER THESE 10 QUESTIONS. IF YOU DO NOT HAVE MEDICARE, PLEASE GO TO THE NEXT PAGE.

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please circle the number based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

<table>
<thead>
<tr>
<th>Activity</th>
<th>NOT AT ALL</th>
<th>A LITTLE</th>
<th>A LOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vigorous activities like running, lifting heavy objects, sports?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. Participating in recreational sport?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3. Moderate activities like moving a table or pushing a vacuum cleaner?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>4. Lifting or carrying items like groceries?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5. Lifting overhead to a cabinet?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6. Gripping or opening a can?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. Handling of small items such as a pen or coins?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. Feeding yourself?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>9. Getting in and out of a chair?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10. Bathing or dressing?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>11. Completing your toileting?</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Total
<table>
<thead>
<tr>
<th>No Difficulty</th>
<th>Mild Difficulty</th>
<th>Moderate Difficulty</th>
<th>Severe Difficulty</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. I have difficulty dressing (ie., putting on a jacket, pulling shirt over head)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I have difficulty bathing or attending to personal hygiene</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I have difficulty gripping objects when writing, cutting food, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I have difficulty performing work tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I have difficulty preparing meals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I have difficulty performing daily household chores, work, or recreational tasks due to headaches</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I have difficulty placing an object overhead (ie., into a cupboard)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I have difficulty performing heavy household chores (ie., cleaning floors and walls)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I have difficulty carry a laundry basket, shopping bag, briefcase or handbag.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I have difficulty carrying objects greater than 10 pounds</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I have difficulty washing, brushing or blow drying hair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I have difficulty reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. I have difficulty with gardening or yard work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25 I have difficulty performing light recreational activities (ie., playing cards, or knitting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. I have difficulty performing recreational activities such as golf, tennis, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27. I have difficulty driving such as when turning my head to look over my shoulder</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28. I have difficulty sleeping through the night due to my injury</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29. I have difficulty with daily tasks due to dizziness or loss of balance related to my injury</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30. I have difficulty looking up to perform overhead activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Total