Patient Information Sheets for DR. FERNYHOUGH , Cervical

PLEASE CIRCLE AND/OR FILL IN THE ANSWERS TO THE FOLLOWING QUESTIONS ON ALL PAGES.

Who referred you to our office?_____Who is your family physician? _____

Other physicians who should receive correspondence about today's visit?_____

Age: ____ Sex: ____ Male Female What do you do for a living? _____

Height _____ Weight _____ Patient's Date of Birth: _____

FOR PHYSICIAN USE ONLY:

For Motor Vehicle Accidents: **Emerg Med Condition? Yes No**

MAIN COMPLAINT: Is your chief complaint?:

Neck Pain	Yes		No
Right Arm Pain	Yes		No
Left Arm Pain	Yes		No
Both Arms	Yes		No
Which arm is worse?	Right	OR	Left
Are your pains variable?	Yes		No

What is the severity of the neck pain? 0 to 10/10?: _____ OR pain ranges from ___/10 to ___/10
Severity of arm pain? 0 to 10?: _____ OR pain ranges from ___/10 to ___/10

The neck pain is worse than the arm pain	Yes	No
The arm pain is worse than the neck pain	Yes	No
Out of 100%, my pain is _____% neck pain and _____% arm pain.		
Do you have headaches along with/from your neck pain?	Yes	No
Do the headaches occur daily?	Yes	No

DURATION OF SYMPTOMS:

How long have you had the neck pain?	____ years	____months	____weeks
How long have you had the arm pain?	____ years	____months	____weeks

Are the symptoms episodic? Yes No
The current episode has been present for ____ years ____months ____weeks

Since the onset of the current symptoms, do you feel better? Yes No
Since the onset of symptoms, do you feel worse? Yes No
If better, what percentage % better: _____ % better
Or do you feel about the same? Yes No

Does the Arm Pain travel down your arm? Yes No
If yes, circle the location(s) where the pain travels to: (circle)
Shoulder Upper arm Biceps Triceps Elbow Forearm Wrist Hand Fingers
Which fingers?: Thumb Index Long Ring Little

Was this pain caused by an **INJURY?** Yes No
What happened?

DESCRIPTION OF PAIN: (circle)
ARM PAIN: Sharp Dull Aching Burning Stabbing Electrical
Is the arm pain constant? Yes No
Is the arm pain intermittent (comes and goes)? Yes No
Is the arm pain excruciating? Yes No
Is the arm pain agonizing? Yes No
Arm pain wakes you up at night? Yes No
Is the arm pain livable? Yes No
The arm symptoms worsen with: Activity Driving Walking Standing Sitting Lying Down
Arm symptoms are improved with: Lying down Sitting Walking
Pins and Needles Sensation down arm? Yes No
Numbness and Tingling down the arm? Yes No
Arm pain is worse when you cough or sneeze? Yes No
Arm pain improves with placing your arm on top of your head? Yes No
Arm bothers you when reaching overhead? Yes No
Arm bothers you when reaching behind? Yes No
Do you have difficulty with your handwriting? Yes No
Difficulty picking up small coins off a table? Yes No
Trouble buttoning buttons? Yes No
Do your hands feel clumsy? Yes No
Do you have problems with your balance? Yes No
Any recent falls because of poor balance? Yes No

NECK PAIN: (Circle) Sharp Dull Aching Burning Stabbing
Is the neck pain constant? Yes No
Is the neck pain intermittent (comes and goes)? Yes No
Is the neck pain excruciating? Yes No
Is the neck pain agonizing? Yes No
Neck pain wakes you at night? Yes No
Is the neck pain livable? Yes No
The neck symptoms worsen with: Activity Driving Walking Standing Sitting Lying Down
The neck symptoms improve with: Lying down Sitting Walking

EXERCISE ROUTINE?: Yes No

How many days per week? _____

Type of exercise: Treadmill Stationary bike Swimming Weightlifting Walking

Other types of exercise: _____

Sports: Tennis Golf Other? _____

Walking: Are you able to walk? Yes No

How far? Unlimited 1 – 2 blocks Less than ½ block

Do you use an assistive device to help you walk? Yes No

What type: Cane Walker Wheelchair

Does leaning forward on a grocery cart improve your symptoms? Yes No

How far can you walk before you must stop and sit? _____ (distance)

Right arm weakness? Yes No

Left arm weakness? Yes No

Is the pain constant? Yes No **OR...**

Is the pain intermittent? (comes and goes) Yes No

Do you have incontinence of urine? Yes No

Date it started: _____

PREVIOUS CERVICAL SPINE SURGERY? Yes No

Surgery Type: Laminoplasty Discectomy Fusion Corpectomy

When? (mo/yr) _____ Where was surgery performed? _____

Surgeon's Name:

The surgery was done due to neck pain Yes No

The surgery was done due to arm pain Yes No Right Left

Did the surgery help? Yes No

TREATMENT FOR THIS PROBLEM THUS FAR: (circle)

What **MEDICATIONS** have you tried for the pain?

Anti-Inflammatories: Celebrex, Mobic, Motrin, Ibuprofen, Naprosyn, Relafen, Daypro, Lodine, Steroid Dosepak, Aleve, Advil.

Narcotics: Percocet, Vicodin, Norco, Codeine, oxycodone, OxyContin, Oxy-IR, Lortab, Duragesic Patch

Other medications tried for this problem: Neurontin, Lyrica, Ultram, Ultracet, Valium, Soma, Skelaxin, Flexeril, Topamax, Cymbalta, Elavil, Tylenol.

What Medications are you taking **currently** for the **pain**? **What dose and how often**?

1. 4.
2. 5.
3. 6.

Have you ever had **cervical facet blocks?** Yes No

When? _____ How many? _____ By whom? _____

Did the injections help? Yes No

Have you ever had **cervical epidural steroid injections?** Yes No

When? _____ How many? _____ By whom? _____

Did the injections help? Yes No

Have you had any **physical therapy** for this problem? Yes No
How many times per week? _____ How many weeks? _____
Did the physical therapy help? Yes No

Have you used a **neck brace?** Yes No
Did the brace help? Yes No

What **other treatments** have you had? Chiropractic. Massage. TENS unit. Acupuncture.
Other? _____
How many visits/sessions of each of these treatments? _____

Any other physicians seen, chiropractors? What treatments were done? Did it help?

PAST MEDICAL HISTORY: Please circle all that you have.

Diabetes	Heart disease	Atrial fibrillation	Coronary artery disease
Stroke	Hypertension	Kidney disease	Heart Attack _____when?
Depression	Panic/anxiety attacks	Irritable bowel	Cancer _____ type?
Osteoporosis	Migraine headaches	Thyroid problems	Rheumatoid arthritis
Osteopenia	Osteoarthritis	Psoriasis	Stomach ulcers
Asthma	Bronchitis	Lung disease	Parkinson's disease
Gastritis	Colon problems	Prostate problems	Hepatitis _____ type?
HIV	AIDS	TMJ syndrome	Insomnia
Hiatal hernia	Liver disease	Fibromyalgia	Polymyalgia rheumatica
Bone marrow cancer		Bone marrow abnormalities	
Bleeding disorder		Platelet abnormalities or platelet problems	

Others:

PAST SURGICAL HISTORY: (Include surgeon's name and year of surgery.)

Pacemaker	Defibrillator implant	Coronary artery bypass graft
Stents -cardiac	Lung cancer surgery	Colon cancer surgery
Stents – aortic	Hip replacement	Knee arthroscopy
Stents – legs	Knee replacement	Shoulder surgery
Kidney surgery	Spine surgery	Breast cancer surgery
Hysterectomy	Gallbladder	Appendectomy
Tonsillectomy		

Other surgeries:

SOCIAL HISTORY:

Do you smoke? Yes No
How many packs per day? _____
Do you drink alcohol ? Yes No
How much per day? _____

Married ? Single? Live alone? In an Assisted Living Facility? In your own home?

MEDICATIONS: Please list.

1. 5.
2. 6.
3. 7.
4. 8.
5. 9.

Others:

Are you currently taking any of the following anticoagulants or anti-platelet medications: (Circle)

Coumadin? Plavix? Aspirin? Baby aspirin? Pradaxa? Xarelto? Aggrenox? Effient? Eliquis? Persantine? ReoPro? Lovenox?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin.
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.

1. 3.
2. 4.

REVIEW OF SYSTEMS:
Do you have any of the following?

Recent weight changes?____	Loss of sensation in perineal/pelvic skin area? _____	
Sinus problems? _____	Blurred Vision? _____	Decreased Hearing? _____
Sore Throat? _____	Abnormal Heart Beat? ____	Heart Attack? _____
High Cholesterol? _____	Thyroid Problems? _____	Fatigue? _____
Shortness of Breath? _____	Chest Pain? _____	Abdominal Pain? _____
Constipation? _____	Diarrhea? _____	Nausea? _____
Vomiting? _____	Unexplained Wt. Loss?____	Blood in Stool? ____
Incontinence of Stool? ____	Incontinence of Urine? ____	Problems w/ Urination? ____
Pain in Legs? _____	Swelling in Legs? _____	Poor Circulation in Legs? ____
Depression? _____	Anxiety? _____	

FAMILY HISTORY:
Do you have a positive family history for any of the following?:

Scoliosis? _____ Osteoporosis? _____ Spinal stenosis? _____

Herniated disk _____ Chronic spine pain_____ Back pain _____

Neck pain _____

DR. FERNYHOUGH PATIENTS BACK AND NECK

Were you involved in a **MOTOR VEHICLE ACCIDENT**? YES NO

DATE OF ACCIDENT: _____

Did you have a seatbelt restraint in place? YES NO Did the airbags deploy? YES NO

Did you have loss of consciousness (black-out) YES NO

Were you the driver or passenger?_____ Front seat or back seat? _____

Were you stopped ? YES NO If so, at traffic light or stop sign? _____

Your vehicle was a: _____(Make) _____(Model)

Which collided with a: _____(Make) _____(Model)

Collision: Rear End Collision vs. Front End Collision vs. Side Impact Collision vs "T-Bone" impact. Was impact on driver's or passenger's side? _____

The name of road or intersection in which the accident occurred? _____ City: _____

Estimated speed of your vehicle?: _____ Estimated speed of other vehicle?: _____

The damage to your car: Car was totaled, or sustained $_____ worth of damage
Was your car drivable after the accident? YES NO

Did you go to the hospital or MD or chiropractor immediately after the accident? YES NO
Name of hospital, MD or chiropractor: _____

Did you go by: Ambulance? You drove yourself? Someone else drove you?

Or, if you went later, when and where? _____

When did the pain begin?: Back pain?_____ Leg pain? _____
Neck pain? _____ Arm pain? _____ Headaches? _____

Have you missed work due to the accident? YES NO If yes, how many days? _____

Do you work Part-time or Full-time? (Please circle)

Have you had any medical care yet for this accident? (chiropractor, neurologist, orthopedic surgeon, general practitioner, physical therapy) YES NO If so, describe in detail. _____

Is the pain better, the same, or overall worse since you began treatment? _____

What % better: _____? **OR** What % worse: _____?

Did you have any pain prior to this accident? YES NO

What was your pain score before the accident? Neck (0 to 10 scale): _____ Back (0 to 10 scale):_____

What percentage % of activity can you tolerate since the motor vehicle accident compared to your pre- motor vehicle accident activity level? _____%

Which specific physical activities are you prevented from doing, due to your current pain, that you were able to do before the accident? Examples: Walking, running, sports, gym, weights, work, etc.

Please List: _____

Have you ever had back or neck pain requiring medical care prior to this accident? (circle) YES NO

If yes, when, and what area of your body was treated? _____

Have you had any prior motor vehicle accidents requiring medical care? (circle) YES NO
If so, give date(s): _____