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NEW SPINE (CERVICAL) PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of visit: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Marital Status: _____

Home Address: _____

_____

Home phone number: _____ Mobile Number: _____ Male ☐ Female ☐

Family Doctor Name and Address: _____

_____

Medical Insurance: ☐ VHI ☐ Aviva ☐ Laya ☐ Glo Healthcare ☐ Garda ☐ ESB ☐ POMA ☐ Self-Pay

Plan type: _____ Policy Number: _____

Who referred you? _____

What is your main problem today? _____

_____

_____

When did your symptoms begin? _____

Are your symptoms the result of an injury? ☐ Yes ☐ No

If yes, what happened? _____

_____

Is there litigation pending as a result of your pain/injury? ☐ Yes ☐ No

Have you been treated by anyone for this problem? ☐ Yes ☐ No If yes, by whom: _____

What investigations have you had to date: ☐ X-rays ☐ MRI ☐ CT ☐ Isotope Bone Scan ☐ PET ☐ Ultrasound

Have you had any treatment to date? ☐ Yes ☐ No If yes: ☐ Medication ☐ Physio ☐ Injections

MEDICAL HISTORY:

Have you ***EVER IN YOUR LIFE*** had any of the following problems?

Tick Box ***ONLY i****f* you have a history of the conditions below:

HEART PROBLEMS:

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Valve Disease
- ☐ Heart Failure, Heart Attack, Heart Surgery
- ☐ Angiogram, Angioplasty (Stenting)

LUNG PROBLEMS:

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep Apnoea

ENDOCRINE PROBLEMS:

- ☐ Diabetes
- ☐ Thyroid - Hyperthyroidism
- ☐ Thyroid - Hypothyroidism

BLADDER OR KIDNEY PROBLEMS:

- ☐ Difficulty passing urine
- ☐ Urinary tract infections
- ☐ Frequency/Urgency

STOMACH OR BOWEL PROBLEMS:

- ☐ Ulcers
- ☐ Diverticulitis
- ☐ Crohn's Disease/Ulcerative Colitis

GENERAL:

- ☐ Previous Clots – Lung or Leg
- ☐ Epilepsy

CANCER:

- ☐ No
- ☐ Yes What kind

ARE YOU ALLERGIC TO ANY MEDICATION?

- ☐ No
- ☐ Yes What happens:

PLEASE LIST ANY **MEDICATION** THAT YOU ARE TAKING NOW (or attach a list):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

BLOOD THINING MEDICATION:

Are you taking any of the following medications:

Pradaxa ☐ Xarelto ☐ Plavix ☐ Warfarin ☐ Aspirin ☐

SURGICAL HISTORY

Please list any surgeries that you have had in the past:

SURGERY	SURGEON	LOCATION	DATE
1			
2			
3			
4			
5			
6			
7			

SOCIAL HISTORY

Do you smoke now? ☐ Yes ☐ No

If Yes, how much? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _____

If No, Did you ever smoke? ☐ Yes ☐ No If Yes, When did you stop? _____

How much did you smoke? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, how much in a week? _____

What is your occupation? _____

Where do you live:

☐ House ☐ Apartment ☐ Nursing Home ☐ Assisted living

With whom do you live? _____

FAMILY HISTORY?

Does anyone in your family have a history of arthritis? _____

If so, have they had joint replacement surgery, and what kind? _____

Are your parents deceased? ☐ Yes ☐ No

If so how did they die:

Mother: Cause: _____ Age _____

Father Cause: _____ Age _____

What is your: HEIGHT? WEIGHT?

PERSON TO CONTACT IN AN EMERGENCY?

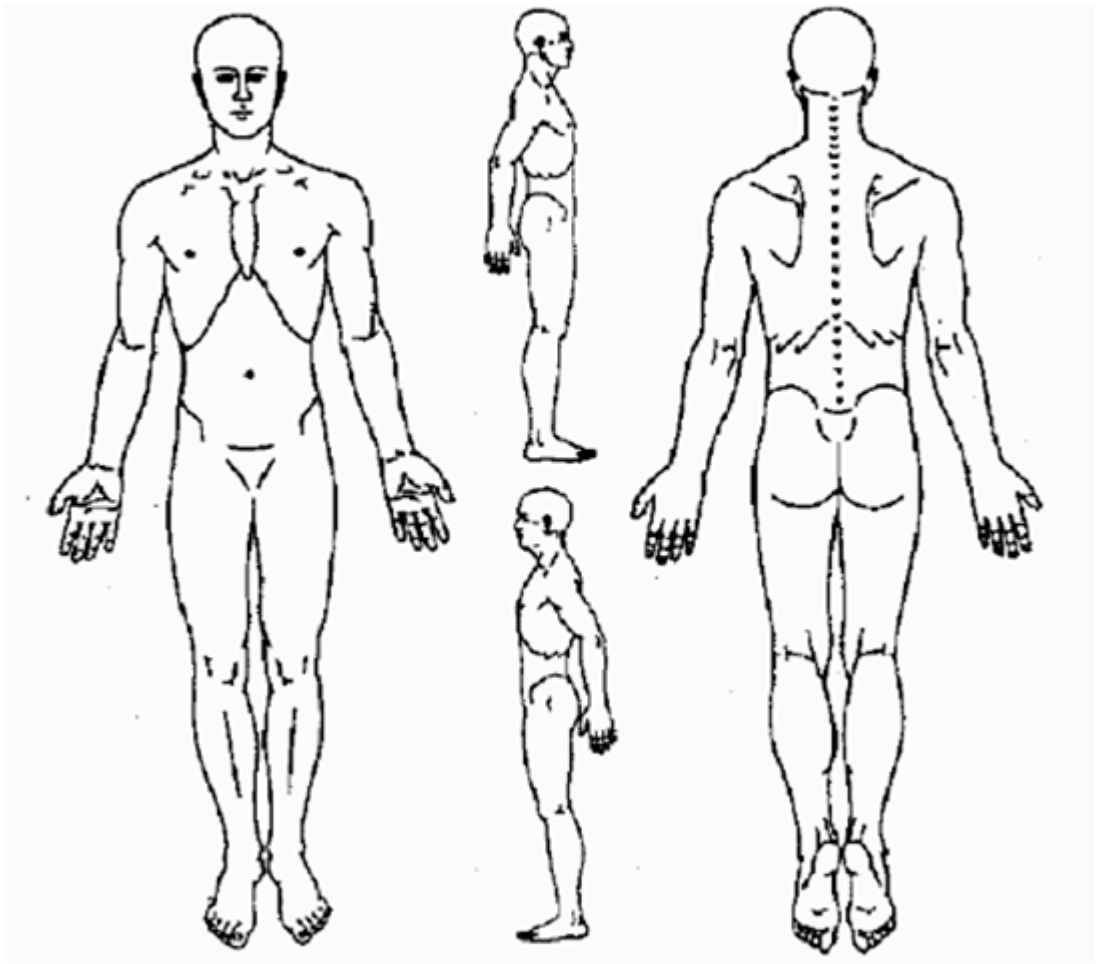
NAME: _____ TEL: _____

NAME: _____ TEL: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

Neck Pain

No pain → Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Arm Pain

No pain → Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Neck Disability Index Questionnaire

Instructions for completion.

Please answer every question by placing a mark on the line that best describes your condition today. We realise you may that two of the statements describe your condition, but **please mark only the line that most closely describes your current condition**.

1. Pain Intensity

- ❒ I have no pain at the moment.
- ❒ The pain is very mild at the moment.
- ❒ The pain is moderate at the moment.
- ❒ The pain is fairly severe at the moment.
- ❒ The pain is very severe at the moment.
- ❒ The pain is the worst imaginable at the moment.

2. Personal Care (e.g., Washing, Dressing, etc)

- ❒ I can take look after myself normally without causing extra pain.
- ❒ I can take look after myself normally, but it causes extra pain.
- ❒ It is painful to look after of myself, and I am slow and careful.
- ❒ I need some help, but I am able to manage most of my personal care.
- ❒ I need help every day in most aspects of self care.
- ❒ I do not get dressed, I wash with difficulty, and stay in bed.

3. Lifting

- ❒ I can lift heavy weights without extra pain.
- ❒ I can lift heavy weights, but it gives extra pain.
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned, for example on a table.
- ❒ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❒ I can lift only very light weights.
- ❒ I cannot lift or carry anything at all.

4. Reading

- ❒ I can read as much as I want to with no pain in my neck.
- ❒ I can read as much as I want to with slight pain in my neck.
- ❒ I can read as much as I want with moderate pain in my neck.
- ❒ I can't read as much as I want because of moderate pain in my neck.
- ❒ I can hardly read at all because of severe pain in my neck.
- ❒ I cannot read at all.

5. Headaches

- ❒ I have no headaches at all.
- ❒ I have slight headaches, which come infrequently.
- ❒ I have moderate headaches, which come infrequently.
- ❒ I have moderate headaches, which come frequently.
- ❒ I have severe headaches, which come frequently.
- ❒ I have headaches almost all the time.

6. Concentration

- ❒ I can concentrate fully when I want to with no difficulty.
- ❒ I can concentrate fully when I want to with slight difficulty.
- ❒ I have a fair degree of difficulty in concentrating when I want to.
- ❒ I have a lot of difficulty in concentrating when I want to.
- ❒ I have a great deal of difficulty in concentrating when I want to.
- ❒ I cannot concentrate at all.

7. Work

- ❒ I can do as much work as I want to.
- ❒ I can only do my usual work, but no more.
- ❒ I can do most of my usual work, but no more.
- ❒ I cannot do my usual work
- ❒ I can hardly do any work at all.
- ❒ I can't do any work at all.

8. Driving

- ❒ I can drive my car without any neck pain.
- ❒ I can drive my car as long as I want with slight pain in my neck.
- ❒ I can drive my car as long as I want with moderate pain in my neck.
- ❒ I can't drive my car as long as I want because of moderate pain in my neck.
- ❒ I can hardly drive at all because of severe pain in my neck.
- ❒ I can't drive my car at all.

9. Sleeping

- ❒ I have no trouble sleeping.
- ❒ My sleep is slightly disturbed (less than 1 hr sleepless).
- ❒ My sleep is mildly disturbed (1-2 hrs sleepless).
- ❒ My sleep is moderately disturbed (2-3 hrs sleepless).
- ❒ My sleep is greatly disturbed (3-5 hrs sleepless).
- ❒ My sleep is completely disturbed (5-7 hrs sleepless).

10. Recreation

- ❒ I am able to engage in all my recreation activities with no neck pain at all.
- ❒ I am able to engage in all my recreation activities, with some pain in my neck.
- ❒ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❒ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❒ I can hardly do any recreation activities because of pain in my neck.
- ❒ I can't do any recreation activities at all.

Please continue on to the next section ⬇

Short Form 12 Health Status Questionnaire

Instructions for completion.

This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

❒	❒	❒	❒	❒	
Excellent		**Very good**	**Good**	**Fair**	**Poor**

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	**Yes, Limited A Little**	**No, Not Limited At All**
2. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling or playing golf	❒	❒	❒
3. Climbing **several** flights of stairs	❒	❒	❒

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. **Accomplished less** than you would like

❒	❒	❒	❒	❒
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the the time**

5. Were limited in the **kind** of work or other activities

❒	❒	❒	❒	❒
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the the time**

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. **Accomplished less** than you would like

❒	❒	❒	❒	❒
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the the time**

7. Didn't do work or other activities as **carefully** as usual

❒	❒	❒	❒	❒
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the the time**

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

❒	❒	❒	❒	❒
Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

	All of the Time	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
9. Have you felt calm and peaceful?	❒	❒	❒	❒	❒
10. Did you have a lot of energy?	❒	❒	❒	❒	❒
11. Have you felt downhearted and blue?	❒	❒	❒	❒	❒

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

❒	❒	❒	❒	❒
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None the time**

For Surgeon use only

Range of Motion:

ROM	R	L
Lumbar Flexion (60°)		
Lumbar Extension(25°)		
Lumbar Lateral Flexion (25°)		
Cervical Flexion (50°)		
Cervical Extension (60°)		
Cervical Lateral Flexion (45°)		
Cervical Lateral Rotation (80°)		

Red Flags:

1. Age <20yrs >55yrs
2. Site.
3. Past Hx. Ca, Steroids, TB, IVDA
4. Night Pain.
5. Weight Loss.
6. Widespread Neurology.
7. Structural Deformity.
8. Abnormal Blood Parameters.
9. Bowel/Urinary Disturbance

Neurology	Motor		Sensory	
	L	R	L	R
C5				
C6				
C7				
C8				
T1				
Reflexes Biceps				
Reflexes Triceps				
Reflexes Supinator				
Reflexes Hoffman				
Scapulohumeral				
Clonus				
Finger Escape				
Spurling's Test				

Neurology	Motor		Sensory	
	L	R	L	R
L2				
L3				
L4				
L5				
S1				
Reflexes KJ				
Reflexes AJ				
Babinski				
Clonus				
Lhermitte's				

Gait: Normal ☐ Spastic ☐ Unsteady ☐ Antalgic ☐ Trendelenberg ☐ Short Leg ☐

Gait: Heel Walking ☐ Toe Walking ☐ Dynamic Rhomberg Test ☐ Other _____

Alignment: Coronal Balanced Yes ☐ No ☐ Sagittal Balanced Yes ☐ No ☐

Lumbar Lordosis: Present ☐ Absent ☐ **Scoliosis:** Present ☐ Absent ☐

Spinal Rhythm Normal ☐ Reversed ☐

Prior incision: Yes ☐ No ☐ If yes, where? _____ **Skin Condition**: _____

Tender: Yes ☐ No ☐ If yes, where? _____

Leg Length: Equal ☐ Left short_____mm Right short_____mmv

Pulses: **Right** DP ☐ PT ☐ **Left** DP ☐ PT ☐

Lasègue's **Right** **Degree_____°** **Left** **Degree_____°**

FNST +ve **Right** Yes ☐ No ☐ **Left** Yes ☐ No ☐

XR Analysis: **Xrays Date**

MRI Date: