Head/Neck/Arm Complaints

Today’s Date: _____/_____/_____              Name:_________________________________________________

Circle the areas on your body where you feel the described sensations, and mark with the appropriate letter(s).

For Office Use Only:

PAIN = P

NUMBNESS = N

TINGLES = T

Quality
1.) Reports
☐ Weakness left arm  ☐ Weakness left leg  ☐ Fever  EXPLAIN__________________________________________
☐ Weakness right arm  ☐ Weakness right leg  ☐ Sexual dysfunction  EXPLAIN__________________________________________
☐ Weakness both arms  ☐ Weakness both legs
☐ Bowel dysfunction  ☐ Bladder dysfunction

2.) Denies
☐ Weakness  ☐ Bowel dysfunction  ☐ Fever  EXPLAIN__________________________________________
☐ Sexual dysfunction  ☐ Bladder dysfunction

3.) Overall Status
Describe how your pain has changed recently.
☐ No change  ☐ Feels better  ☐ Feels worse  ☐ Requiring more medication

4.) Is this a similar or recurrent problem?
☐ Deny previous episodes  ☐ Recurrent problem for __________________________  ☐ Similar to previous____________________________________

5.) Please circle the number which best describes your pain level, or if the pain varies, list a range (0-No Pain and 10-Worst Pain): 0 1 2 3 4 5 6 7 8 9 10 or Range:_________________________

6.) Sensations
☐ Aching ☐ Burning ☐ Cramping ☐ Dullness ☐ Throbbing ☐ Feeling Asleep
☐ Heaviness ☐ Numbness ☐ Pins/Needles ☐ Sharpness ☐ Tingling ☐ Other_________________________

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### Timing
8.) What activities or positions **RELIEVE or DECREASE** your pain?
- Nothing
- Bending Neck Backward
- Heating Pad
- Raising Arms Up
- Resting
- Any Movement
- Cervical Collar
- Hot Bath/Shower
- Sitting
- Turning Head
- Bending Neck Forward
- Cold Packs
- Lying on Back
- Standing
- Other, describe:

9.) What activities or positions **INCREASE** your pain?
- Nothing
- Bending Neck Backward
- Extreme of Motion
- Lifting
- Standing
- Movement
- Cervical Collar
- Heating Pad
- Lying on Back
- Turning Head
- Bending Neck Forward
- Cold Packs
- Hot Bath/Shower
- Sitting
- Inspiration
- Cough/sneeze
- Straining w/ Bowel Movement
- Other, describe:

### Previous Treatment
10.) Which of these treatments have **improved** your condition?
- Back Brace
- Bed Rest
- Chiropractic
- TENS/e-stim
- Exercise
- Facet Injection
- Meds OTC
- Pain Meds
- Steroid Meds
- Musc.Relaxers
- Neurontin, Lyrica
- Epidural Injection
- Phys Therapy
- Occ. Therapy
- Ultrasound
- Rhizotomy
- Traction
- Steroid Injection
- Spinal Decomp. Therapy
- NSAIDs
- Heat
- Cold Pack
- Restrict Activity
- Other

11.) Which of these treatments did **not improve** your condition?
- Back Brace
- Bed Rest
- Chiropractic
- TENS/e-stim
- Exercise
- Facet Injection
- Meds OTC
- Pain Meds
- Steroid Meds
- Musc.Relaxers
- Neurontin, Lyrica
- Epidural Injection
- Phys Therapy
- Occ. Therapy
- Ultrasound
- Rhizotomy
- Traction
- Steroid Injection
- Spinal Decomp. Therapy
- NSAIDs
- Heat
- Cold Pack
- Restrict Activity
- Other

12.) Which of these treatments are you currently receiving?
- Back Brace
- Bed Rest
- Chiropractic
- TENS/e-stim
- Exercise
- Facet Injection
- Meds OTC
- Pain Meds
- Steroid Meds
- Musc.Relaxers
- Neurontin, Lyrica
- Epidural Injection
- Phys Therapy
- Occ. Therapy
- Ultrasound
- Rhizotomy
- Traction
- Steroid Injection
- Spinal Decomp. Therapy
- NSAIDs
- Heat
- Cold Pack
- Restrict Activity
- Other

13.) Who were you previously treated by?
- N/A
- Neurosurgeon
- Neurologist
- This Office
- Orthopedic Surgeon
- Chiropractor
- Pain Clinic
- Other

When was your most recent MRI, CT, or XRAY of problem area?

Where was it performed?

### Office use only:
Which of these treatments have not been attempted or prescribed?
- Back Brace
- Bed Rest
- Chiropractic
- TENS/e-stim
- Exercise
- Facet Injection
- Meds OTC
- Pain Meds
- Steroid Meds
- Musc.Relaxers
- Neurontin, Lyrica
- Epidural Injection
- Phys Therapy
- Occ. Therapy
- Ultrasound
- Rhizotomy
- Traction
- Steroid Injection
- Spinal Decomp. Therapy
- NSAIDs
- Heat
- Cold Pack
- Restrict Activity
- Other