**CERVICAL SPINE QUESTIONNAIRE—Dr. Mitsunaga**
Please print legibly in black ink. This form will become part of your medical record.

**PART 1: GENERAL INFORMATION**

1) Name:

2) Today's Date:

3) Date of birth: Age: Gender: Height: Weight:

4) Are you ☐Left handed or ☐Right handed?

5) Which surgeon are you being referred to (check one): ☐Kyle Mitsunaga ☐Lance Mitsunaga ☐Morris Mitsunaga ☐None specified

6) Which physician referred you here? _____

7) Who is your primary care physician?
_____

**PART 2: NECK/ARM PAIN HISTORY**

1) What is your **main symptom** (for example: neck pain, arm pain/weakness/numbness, trouble walking): _____

_____

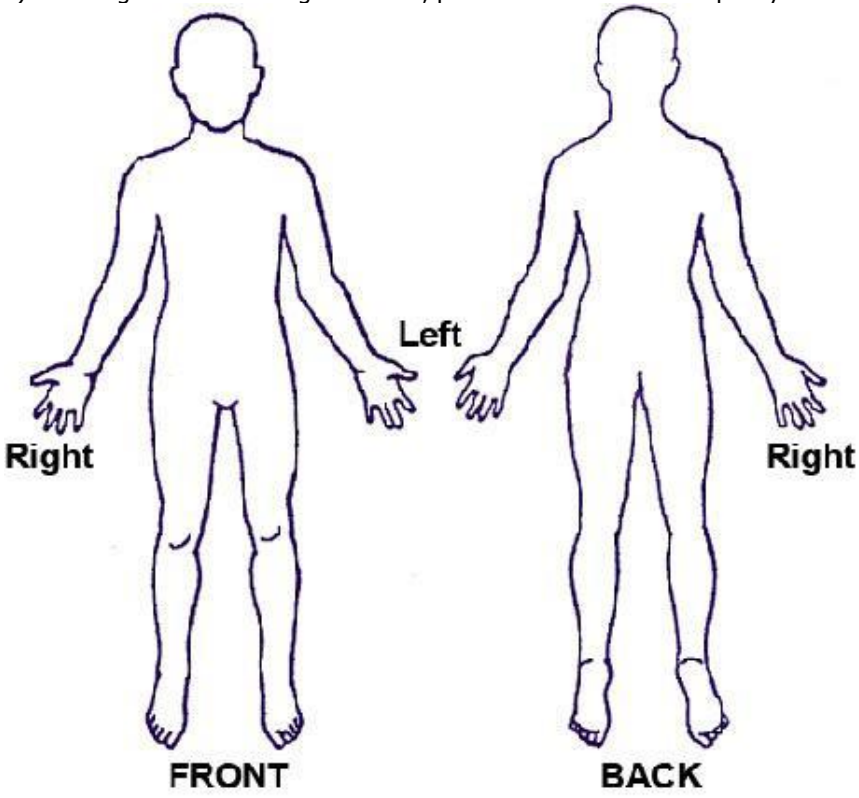
2) Out of 100%, what % of your pain is in your **neck versus upper extremities**? Neck: _____%. Upper extremities: _____%.

3) If you have upper extremity pain, what % is in your **left versus your right upper extremity**? Left:_____%. Right: _____%

4) When did you **first start** experiencing this pain (month/year)? _____

5) Where is the pain **located** (for example: neck, left/right shoulder, shoulder blade, arm, forearm, hand, fingers)?

6) Pain diagram: In the diagram below, place an "X" in the exact spots you are feeling pain or numbness



7) How did this pain come on (please select one): ☐All of a sudden ☐Gradually over time

8) Is your pain associated with any **specific injuries or accidents** (such as falling, lifting, direct blow, work-related injury, car accident)? ☐YES ☐NO If yes, please describe:_____

_____

_____

9) Over the past 2 months, how has your pain **changed**? ☐Getting worse ☐Staying the same ☐Getting Better

10) How would you **describe** this pain: ☐Constant ☐Intermittent ☐Waxes/wanes ☐Central ☐Dull ☐Aching ☐Sharp ☐Burning ☐Nuisance ☐Throbbing ☐Bearable ☐Unbearable ☐Excruciating ☐Manageable ☐Unmanageable ☐Terrible

11) On a scale of 1 to 10, what is your pain level **currently**? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

12) On a scale of 1 to 10, what is the **lowest** your pain ever gets? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

13) On a scale of 1 to 10, what is the **worst** your pain ever gets? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

14) Have you had any **prior spine surgeries**? ☐Yes ☐No If yes, please list the 3 most recent spine surgeries:

1. Date:_____ Surgeon:_____ Part of spine: ☐Cervical ☐Thoracic ☐Lumbar
   Type of procedure: ☐Anterior Fusion ☐Posterior Fusion ☐Laminectomy/decompression
2. Date:_____ Surgeon:_____ Part of spine: ☐Cervical ☐Thoracic ☐Lumbar
   Type of procedure: ☐Anterior Fusion ☐Posterior Fusion ☐Laminectomy/decompression
3. Date:_____ Surgeon:_____ Part of spine: ☐Cervical ☐Thoracic ☐Lumbar
   Type of procedure: ☐Anterior Fusion ☐Posterior Fusion ☐Laminectomy/decompression

15) Is your pain brought on or **aggravated** by any of the following? Select all that apply: ☐Turning your neck a certain way ☐Using your arms/hands a certain way ☐Lifting objects ☐Coughing ☐Sneezing ☐Bearing down with bowel movement ☐Lying down ☐Sitting ☐Standing ☐Walking ☐Bending over ☐ Certain times of the day ☐Morning ☐Early afternoon ☐LRW afternoon ☐Night ☐Other:_____

16) Is there anything that **relieves** the pain (such as certain neck or arm positions, activities, medications, ice/heat, etc.):

17) How far can you comfortably **walk** (e.g. few steps, 1 block, ½ mile)? _____. What is the limiting factor for your walking (e.g. pain, weakness, balance problems, etc.):

18) Do you have any **weakness** in your **upper extremities** (such as your shoulders, elbows, wrists, fingers)? ☐Yes ☐ No If yes, where is this weakness (for example, lifting left/right arm overhead, straightening/bending left/right elbow, grasping with left/right hand, etc):

If yes, please give 1 or 2 specific examples of when you notice this weakness (for example: lifting objects overhead, carrying or holding onto objects, using hands for certain activities, etc):

_____

19) Do you have trouble **using your hands** for any of the following activities: ☐pick up small objects like coins ☐button your buttons ☐use a fork/knife ☐use chopsticks ☐text/dial on a cell phone type ☐write with your hand

20) Do you have any **numbness** in your **upper extremities** (e.g. shoulders, arm, forearm, wrist, hand/fingers)? ☐Yes ☐No
If yes, where is the numbness (for example, left/right shoulders, arm, forearm, hand, fingers):

21) Do you have any **numbness** in your **lower extremities** (e.g. groin, buttocks, thigh, leg/calf, foot, toes)? ☐Yes ☐No
If so, where is the numbness (for example, left/right groin, thigh, leg/calf, foot, toes): _____

_____

22) Do you have any **weakness** in your **lower extremities?** ☐Yes ☐No If yes, which lower extremity? ☐Left ☐Right
Please give 1 or 2 specific examples of when you notice this weakness (such as going up/down stairs, sensation of legs "giving out" or buckling when walking, etc):_____

_____

23) Do you have any trouble with your **gait or balance**? ☐Yes ☐No If so, please describe in 1 or 2 sentences:_____

_____

24) Do you have any **trouble standing upright**? (for example, do you feel yourself leaning too far forward, too far to the left or right?)
☐Yes ☐No If yes, please describe:_____

_____

25) To what degree are your neck/arm problems affecting your **quality of life**? ☐Significantly ☐Moderately ☐Minimally ☐Not at all
Please give an example of how your quality of life is being affected (for example, are there certain recreational/social activities you enjoy but are no longer able to do?) _____

_____

26) Do you have any trouble with your **day to day activities** such as going to work, dressing, cooking, cleaning, driving? ☐Yes ☐No.
If yes, please give examples of some of the activities you find most difficult:

27) Do you use any of the following **assistive devices** (Please check all that apply): ☐Canes ☐Walkers ☐Wheelchairs
If so, how long have you been using this device?

28) Which of the following treatments have you tried that you found ***helpful***? Please circle/check any that apply:

☐**Opiates:** Tylenol #3, hydrocodone, oxycodone, Norco, Percocet, Vicodin, morphine, oxycontin, oxycodone, tramadol, methadone.

☐**Neuropathic agents:** Lyrica (pregabalin), Neurontin (gabapentin), Cymbalta (duloxetine), Pamelor/Aventyl (nortriptyline)

☐**Topical agents**: Salonpas, Lidoderm patch, fentanyl patch.

☐**Anti-inflammatories:** Mobic (meloxicam), Motrin, Aleve, ibuprofen, naproxen.

☐**Muscle relaxants:** Flexiril (cyclobenzaprine), temazepam, tizanidine, Valium (diazepam), skelaxin (metaxalone).

☐**Steroids** (such as Medrol dosepak, methylprednisolone)

☐**Other medications:**_____

☐**PHYSICAL THERAPY**

What did the therapy include? ☐Home exercise program ☐Massage ☐Traction ☐Electrical stimulation ☐Ultrasound ☐Paraffin ☐Therapeutic ☐Taping ☐Heat/thermal agents ☐Ice ☐Ionto/phonophoresis ☐Postural education/ergonomics ☐Strengthening stretching/range of motion ☐Exercises ☐Weight loss ☐Core strengthening ☐Aquatic therapy ☐Balance/proprioception ☐Gait training

☐**Aerobic exercises such as:** _____

☐**Home exercises/stretching/therapy**

☐**Lumbar epidural steroid injections:**
How many have you undergone?
When was the most recent one performed (Month/year):
Which doctor performed this injection?

What % of your pain is relieved with the injections?
How long does the benefit last?

☐**Miscellaneous** ☐neck brace ☐TENS unit ☐Chiropractor ☐Acupuncture ☐Weight loss ☐Pool therapy ☐Activity modification ☐Inversion table ☐Massage

☐**Other treatments you have found helpful:** _____

29) Which of the following treatments have you tried that you found ***NOT helpful***? Please circle any that apply:

☐**Opiates:** Tylenol #3, hydrocodone, oxycodone, Norco, Percocet, Vicodin, morphine, oxycontin, oxycodone, tramadol, methadone.

☐**Neuropathic agents:** Lyrica (pregabalin), Neurontin (gabapentin), Cymbalta (duloxetine), Pamelor/Aventyl (nortriptyline)

☐**Topical agents**: Salonpas, Lidoderm patch, fentanyl patch.

☐**Anti-inflammatories:** Mobic (meloxicam), Motrin, Aleve, ibuprofen, naproxen.

☐**Muscle relaxants:** Flexiril (cyclobenzaprine), temazepam, tizanidine, Valium (diazepam), skelaxin (metaxalone).

☐**Steroids** (such as Medrol dosepak, methylprednisolone)

☐**Other medications:**

☐**PHYSICAL THERAPY**

What did the therapy include? ☐Home exercise program ☐Massage ☐Traction ☐Electrical stimulation ☐Ultrasound ☐Paraffin ☐Therapeutic ☐Taping ☐Heat/thermal agents ☐Ice ☐Ionto/phonophoresis ☐Postural education/ergonomics ☐Strengthening stretching/range of motion ☐Exercises ☐Weight loss ☐Core strengthening ☐Aquatic therapy ☐Balance/proprioception ☐Gait training

☐**Aerobic exercises such as:** _____

☐**Home exercises/stretching/therapy**

☐**Lumbar epidural steroid injections:**

How many have you undergone?
When was the most recent one performed (Month/year):
Which doctor performed this injection?
What % of your pain is relieved with the injections?
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☐**Miscellaneous** ☐Lumbar brace ☐TENS unit ☐Chiropractor ☐Acupuncture ☐Weight loss ☐Pool therapy ☐Activity modification ☐Inversion table ☐Massage

☐**Other treatments you have found *NOT helpful:*** _____

30) Do you have any **bowel control issues** (such as incomplete emptying of your bowels when you try to have a bowel movement, or bowel incontinence) ☐Yes ☐No? If so, please describe the nature of this problem and how long it has been going on:

_____

31) Do you have any **bladder control issues**? (such as incomplete emptying of your bowels when you try to urinate, or urine incontinence) ☐Yes ☐No? If so, please describe the nature of this problem and how long it has been going on:

_____

32) Do you feel **generally well**? ☐Yes ☐No If no, please describe:_____

33) Have you had any **unintentiona**l weight loss ☐Yes ☐No? If yes, how much weight have you lost?:_____ pounds. Over what period did you lose this weight? _____

34) Have you had any of the following recently (select any that apply)? ☐Fevers ☐Chills ☐Night sweats ☐Night pain

35) Is there a **workers compensation claim** for this injury? ☐Yes ☐No

**Part 3: Past Medical/Surgical History**

1) Select all that apply: ☐Heart disease ☐Heart failure ☐Heart attack ☐Lung disease ☐High blood pressure ☐High cholesterol ☐Stroke ☐Diabetes ☐Cancer type_____ ☐Gastric reflux ☐Ulcer ☐Kidney disease ☐Liver failure ☐Hepatitis A, B, or C ☐HIV/AIDS ☐Low blood count/anemia ☐Bleeding disorders ☐Other medical issues:_____

2) Other than spine surgery, please list the last 5 surgeries you have had on other parts of your body:

1. Date:_____ Procedure: _____
2. Date:_____ Procedure: _____
3. Date:_____ Procedure: _____
4. Date:_____ Procedure: _____
5. Date:_____ Procedure: _____

3) Please list all of the **medications** that you take:

4) Do you have any **drug allergies**? ☐Yes ☐No. If yes, please list the drug and side effect _____

_____

5) **Family history:** Is there anyone in your family with any spine problems? ☐Yes ☐ No.
If yes, which family member? _____. If yes, what type of spine problem?

**PART 4: SOCIAL HISTORY**

**1) Work status**: ☐Homemaker ☐Working ☐Retired ☐Disabled ☐On leave/unemployed
**2) Occupation:** _____
**3) Marital status**: ☐Single ☐Married ☐Divorced ☐Widowed ☐Cohabitating
**4) # of Children**:_____

**5) Who do you live with?** ☐Alone ☐With someone else. If you live with someone else, who do you live with? _____
**6)** Do you **smoke**? ☐Yes ☐No. If yes, how many packs per day? _____ packs per day. How many years? _____ years.

**7) Alcohol consumption**: ☐Never or rare ☐Social ☐Frequently drunk (more than twice a week) ☐Alcoholic ☐Recovering alcoholic.
If you are a recovering alcoholic, # of years sober:_____
**8) Drug use**: ☐Never ☐In the past ☐Current IV drug use

**9) Recreations/hobbies:** _____

_____

**PART 5: REVIEW OF MEDICAL PROBLEMS** (please check all that apply):

**General**: ☐Fevers ☐Chills ☐Weight changes ☐Night pain ☐Night sweats ☐Unintentional weight loss ☐Recent colds or flu

**Head/eyes/ears/nose/throat**: ☐Eye problems ☐Ear problems ☐Hearing problems ☐vision changes ☐Sore throat ☐Runny nose

**Cardiac**: ☐Chest pain ☐Heart palpitations ☐Heart attack ☐Cardiac arrythmias

**Respiratory**: ☐Cough ☐Wheeze ☐Asthma ☐Lung problems ☐Shortness of breath

**Gastrointestinal**: ☐Gastric reflex ☐Diarrhea ☐Constipation ☐Intestinal/abdominal problems ☐nausea ☐vomiting

**Musculoskeleta**l: ☐Problems with joints ☐Muscle problems ☐Bone problems

**Integument:** ☐skin changes ☐hair problems ☐nail problems

**Genitourinary**: ☐Urinary hesitancy ☐Painful urination ☐Urinary incontinence (loss of bladder control)

**Endocrine**: ☐Heat or cold intolerance ☐Diabetes

**Hematologic:** ☐Bleeding problems ☐bruising problems

**Neurologic**: ☐stroke ☐seizures

**Psychiatric:** ☐ anxiety ☐depression ☐schizophrenia

**Other medical problems:** _____