

Cervical Spine Initial Form - Twin Cities Orthopedics

STICKER FIELD

Date of Surgery: (MM/DD/YYYY)

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What's patient's height?

<input type="text"/>	Feet	<input type="text"/>	<input type="text"/>	Inches
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What's patient's weight?

<input type="text"/>	<input type="text"/>	<input type="text"/>	Pounds
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Marking Instructions: Please FILL in the appropriate boxes or circles
Printing Instructions: Please Print in ALL CAPITAL letters & keep all letters within the box

Please select your surgeon from the list below:

- Jeffrey C Dick, MD
- David C Holte, MD
- John E Sherman, MD
- Michael D Smith, MD



Race/Ethnicity (optional question): Please select one

- White
- Black or African-American
- Hispanic or Latino
- Asian
- American Indian and Alaska Native
- Native Hawaiian and Other Pacific Islander
- Other



Patient Demographics Information

Education Level: Please select one

- No schooling completed
- Less than 12th grade
- 12th grade, NO DIPLOMA
- High school DIPLOMA or the equivalent (for example: GED)
- Some college credit, but less than 1 year
- Associate degree (for example: AA, AS)
- Bachelor's degree (for example: BA, AB, BS)
- Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
- Professional degree (for example: MD, DDS, DVM, LLB, JD)
- Doctorate degree (for example: PhD, EdD)

Do you currently smoke cigarettes or use any other tobacco products ? (Mark one response.)

- Yes
- No, I quit smoking or using any other tobacco products less than 6 months ago.
- No, I quit smoking or using any other tobacco products more than 6 months ago.
- No, I have never smoked or used any other tobacco products . (If select this choice; GO TO NEXT PAGE)

How many years have you been smoking/using or did you smoke/use cigarettes or any other tobacco products?

Years

On average, how many packs of cigarettes/tobacco products do you or did you smoke each day?

- ¼ pack per day or less (5 cigarettes or less)
- ½ pack per day
- 1 pack per day
- 1 ½ packs per day
- 2 packs or more per day



Surgery History & Comorbidities

Have you ever had any “neck related spine surgery” previously?

- No. I have never had “neck related spine surgery” previously
- I had 1 surgery
- I had 2 surgeries
- I had 3 or more surgeries

Comorbidities:

YES **NO**

Do you have heart disease?

If you have heart disease, does it limit your activities?

Do you have lung disease?

If you have lung disease, does it limit your activities?

Do you have diabetes?

Do you have fibromyalgia?

Please continue to the next page



Please answer each question by filling the circle that best describes your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed



Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort



Anxiety/Depression

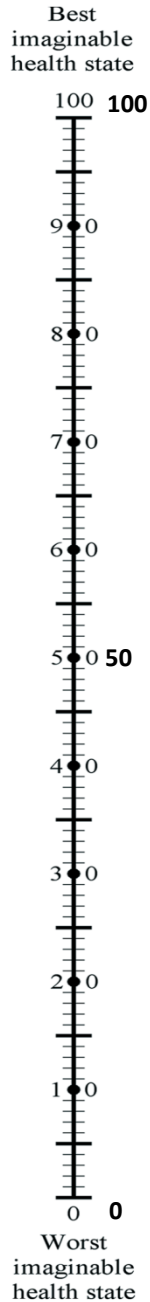
- I am not anxious or depressed
- I am moderately anxious and depressed
- I am extremely anxious or depressed

Please continue to the next page



To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked **100** and the worst state you can imagine is marked **0**.

We would like you to use this scale to determine how good or bad your own health is **today**, in your opinion. Please enter your health state score in the section on right side of the scale.



Health State Score (0-100)

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Please enter your health state score above

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Please continue to the next page



NECK DISABILITY INDEX

This questionnaire is designed to give us information about how your NECK (or ARM) trouble affects your ability to manage your daily life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

1. Pain intensity



- I have no neck 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

- I can look after myself normally without causing extra neck pain.
- I can look after myself normally, but it causes extra neck pain.
- It is painful to take care of myself, and I am slow and careful.
- I need some help but 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 causing extra neck pain.
- I can lift heavy weights, but it gives me extra neck pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- I can lift only very light weights.
- I cannot lift or carry anything at all.



4. Work

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



5. Headaches

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

6. Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

7. Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

8. Driving

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



9. Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

10. Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

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Please continue to the next and last questionnaire



VISUAL ANALOG PAIN SCALE – NECK PAIN

Indicate the severity of your pain today by marking X in one circle that most applies to you.
See the example below:



Migraine Pain:

0 No Pain 10 Worst Possible Pain

Neck Pain Questionnaire

NECK PAIN:

0 No Pain 10 Worst Possible Pain

RIGHT ARM PAIN:

0 No Pain 10 Worst Possible Pain

LEFT ARM PAIN:

0 No Pain 10 Worst Possible Pain

HIP PAIN: If you had donor bone removed from iliac crest, describe your hip pain.

0 No Pain 10 Worst Possible Pain

