



CERVICAL SPINE CLINICAL QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please describe what specific complaints/symptoms have been most bothersome to you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How long have you had these complaints/symptoms? \_\_\_\_\_

4. Do you have a history of cancer? If so, what type? \_\_\_\_\_

5. Are these symptoms the:  same  better  worse

6. Do you have neck pain?  yes  no

7. Do you have pain, numbness, weakness or tingling in any of the following areas:

	Right	Left
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Lower Arm	<input type="checkbox"/>	<input type="checkbox"/>
Hand and Fingers	<input type="checkbox"/>	<input type="checkbox"/>

Which fingers are most involved? \_\_\_\_\_

8. Do you have bowel and/or bladder problems?  yes  no

9. Do you have leg weakness or tingling?  yes  no

10. Have you had a prior significant injury to your neck/spine?  yes  no

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_