

Neck & Upper Extremity Assessment

Patient Name: _____

Visit Date ____/____/____

- My worst symptom is:
- Pain
 - Numbness, tingling or loss of sensation
 - Weakness
 - Other: _____

PAIN

I have **NO** pain

My pain is never lower than
a ___ out of 10

At it's worst the pain is
a ___ out of 10

Pain seems to hover about
a ___ out of 10.

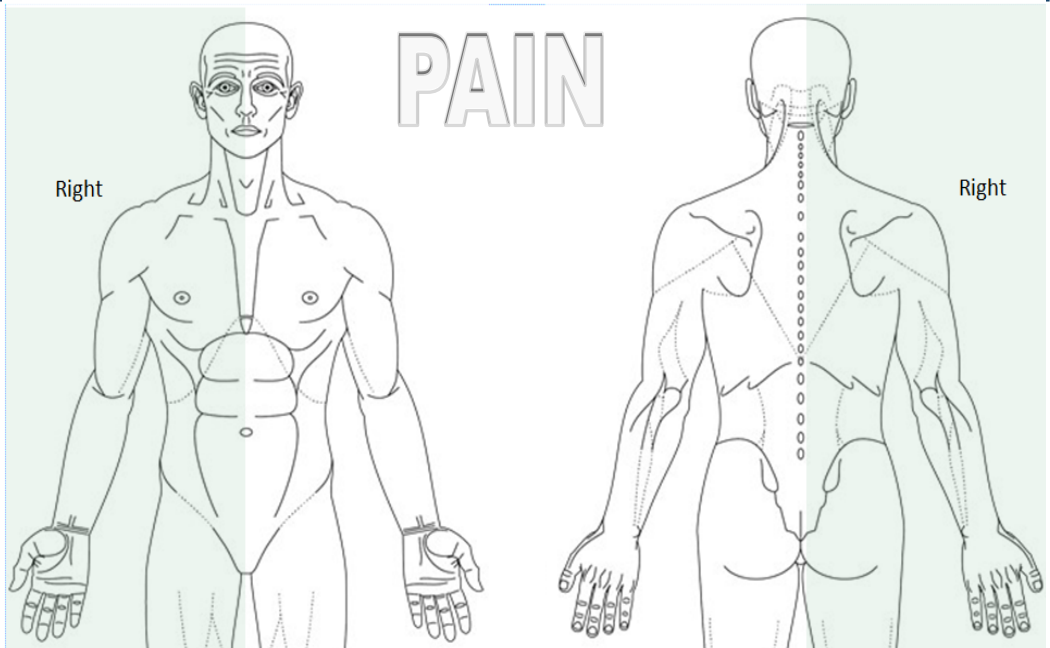
Quality of pain:

- Sharp/stabbing
- Throbbing
- Dull/achy
- Burning
- Electrical/zapping
- _____

My neck pain is more than my arm pain

My arm pain is more than my neck pain

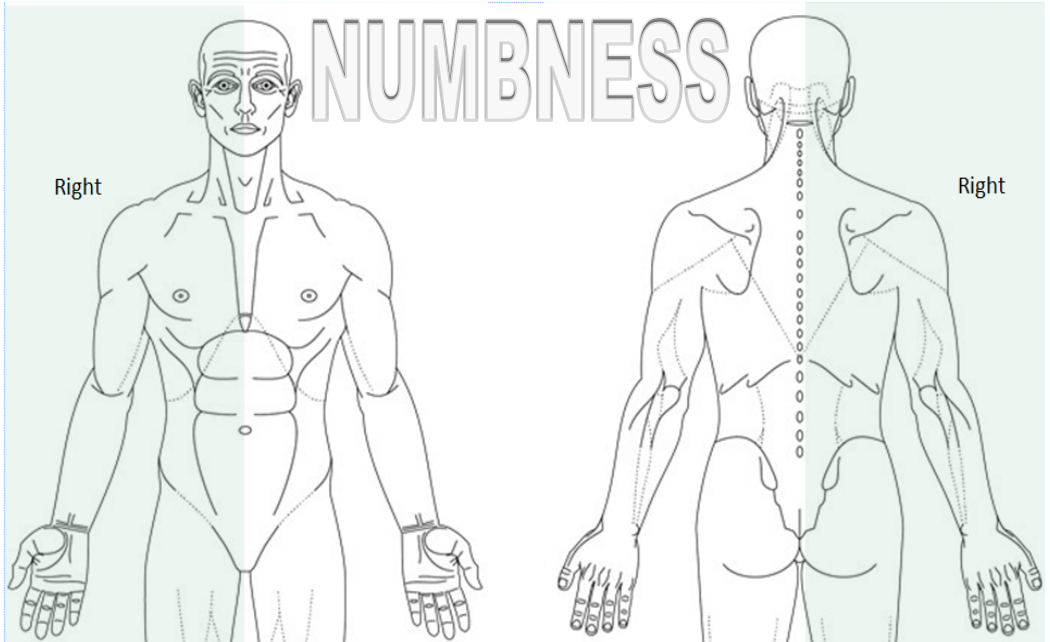
Neck and arm pain are equal



Numbness Tingling or Loss of Sensation

I do **NOT** have any loss of sensation or numbness/tingling

I **DO** have loss of sensation/numbness/tingling have - it is in a similar location to pain



Weakness

I am *RIGHT* handed I am *LEFT* handed

Any difficulty with any of the following?:

	RIGHT	LEFT	None
<u>Lifting your arm to the side</u> (like when reaching for something on a high shelf or putting on a shirt?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Bending your arm at the elbow to bring your hand toward your face</u> (like when eating, brushing your teeth, or lifting objects?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Straightening your arm at the elbow</u> (like when pushing open a door or getting up from a chair using your arms?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Bending your wrist forward</u> (like when trying to pour water from a bottle or push open a door?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Straightening your wrist</u> (like when trying to lift your hand to wave or hold something like a tray?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gripping objects tightly</u> (like when holding a pen, squeezing a bottle, or making a fist?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Straightening your fingers</u> (like when opening your hand, releasing objects, or performing gestures such as waving?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Coordination—are you clumsy, do you have difficulty with fine motor</u> (like difficulty buttoning buttons or picking up pills?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When I walk the ground feels unusual and I don't have good balance.

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Other Symptoms

ONSET

When did your symptoms start and what were you doing at the time?

Progression

Since your symptoms began, have they improved, worsened, or stayed the same?

What makes your symptoms worse?

What interventions have you recently tried to improve your symptoms?

- Rest Ice / Heat Brace Over the counter pain medications Prescription pain medications
 Chiropractic therapy Massage therapy Injections Physical therapy ___ wks/6mos

What makes your symptoms better?

Lifestyle

What areas of your life are significantly impacted by your current condition?

- Work Exercise & fitness Sleep Sex-life Weight gain Weight loss
 Household chores Enjoyable activities Mental well-being Hygiene