Cervical Spine and Upper Extremity Questionnaire: _____

Please Answer the questions to the best of your ability in order for us to be of help to you.

Describe your present symptoms:_____

_____

When did the symptoms start?_____

How/Why did the Symptoms start?_____

_____

What was the first Symptom you felt?_____

Are the Symptoms there ***ALL*** the time? _____ Do they come and go?_____

Does the pain disturb your sleep? _____ If yes, does it keep you from getting to sleep or wake you up from sleep"?_____

If it wakes you, how long are you asleep generally before it wakes you?_____

Do you have any of the following symptoms? (circle if Yes, cross out if No): Dizziness Tinnitus Nausea Pain Swallowing

Have you had any change in your bladder function with this episode?_____

Have you had an issue with bladder or bowel function not related to this episode?_____

Have you had any weakness in your arm or hand?_____

Have you had any unexplained weight loss?_____

Please put a "B" for Better, "W" for Worse and "N" for No Effect beside each of the following activities: This is a very helpful component of the evaluation.

Bending_____ Turning_____ Reading/Computer use_____ Sitting _____ Lying_____ Rising from Lying_____

First thing in the AM_____ As the day progresses_____ In the PM_____ Coughing____

Is there anything that relieves the symptoms? Meds/heat etc_____

Have you had a recent or a significant fall?_____

Have you had Neck Surgery?_____ Epidural Injections?_____

Have you experienced these symptoms before?_____ When?_____

Have you been treated for this previously? _____ Was it helpful?_____

Is there anything else you believe it would be important for me to know?_____

Thank You! Marjorie R. Rodd P.T., Cert. MDT