Neck and Upper Back Pain Exam

Patient Last Name _____ **First Name** _____ **MI** ____ **Date** _____ **DOB**_____
Address _____ **City** _____ **State** _____ **Zip** _____
Patient ID Number _____ **Dr. Last Name** _____ **First Name** _____ **MI**____
Injury/Illness related to: ☐work ☐auto ☐other

History:

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation/Location: _____

Past History: _____

Wt: _____ **Ht:**_____ **BP:**_____/_____ **Pulse:**_____**bpm: reg / irreg** **Age:**_____

Cerv ROM	Normal	Exam	Pain (0-4)	Maneuver	Right	Left
Flexion	60-80°					
Extension	70°			VAS (rot & ext)		
R Lat'l Flx	30-45°			Rhomberg's		
L Lat'l Flx	30-45°			Babinski sign	Present/Absent	Present/Absent
R Rot'n	70-90°			Cerv compress'n	Neg /Local Pain / Radiation	Neg/Local Pain / Radiation
L Rot'n	70-90°			Cerv Distraction	Relief/Increase Pain	Relief/Increase Pain

DTR's (0-5)	Right	Left	Dermatome (pinwheel)	Right	Left	Motor Strength (0-5)	Right	Left
C5 (biceps)			C5 (Lat'l arm)			C5 (*Deltoid*/Biceps)		
C6 (brachioradialis)			C6 (Lat'l forearm/hand)			C6 (*Wrist extensors*/ biceps)		
C7 (triceps)			C7 (Middle finger)			C7 (*Wrist flx*/ finger ext/ tricep)		
L4 (patella)			C8 (Medial forearm/hand)			C8 (Finger flex/ hand intrinsic)		
S1 (Achilles)			T1 (Medial arm)			T1 (Hand intrinsics)		

Exam/Maneuver	Right	Left	Review of Systems	
Valsalva			☐ N Cardiovascular	☐ Y
Soto-Hall			☐ N Musculoskeletal	☐ Y
Roos/E.A.S.T			☐ N Respiratory	☐ Y
Phalens			☐ N Neurological	☐ Y
Tinel Tap			☐ N GI	☐ Y
Spasm / TTP: level(s)			☐ N GU	☐ Y
			☐ N Endocrine	☐ Y

Pain intensity according to patient None 0 1 2 3 4 5 6 7 8 9 10 Severe

Primary Diagnosis: _____ ☐☐☐☐☐☐☐☐☐☐☐

Secondary Diagnosis: _____ ☐☐☐☐☐☐☐☐☐☐☐

Dx:
☐ 847.0 C Sp/St
☐ 724.5 Facet Syn
☐ 847.1 TH Sp/St
☐ 723.4 CnervCo
☐ 723.3 CBRSynd
☐ 722.4 C DJD
☐ 784.0 Headach
☐ 723.5 C Torticol
☐ 739.1 C Subux
☐ 739.2 T Sublux
☐ 723.4 Br Neurit
☐ 724.4 IntCostN
☐ Other _____

Outcome Assessment Tool: _____ **Score: 1st Visit**_____ **8th Visit** _____
Current Treatment Plan w/Goals: _____

Proposed Treatment Plan: From: ____/____/____ **To:** ____/____/____ **Number of visits Requested:**_____

_____ _____
Doctor's Signature **Date**