



Portland NEUROSURGERY

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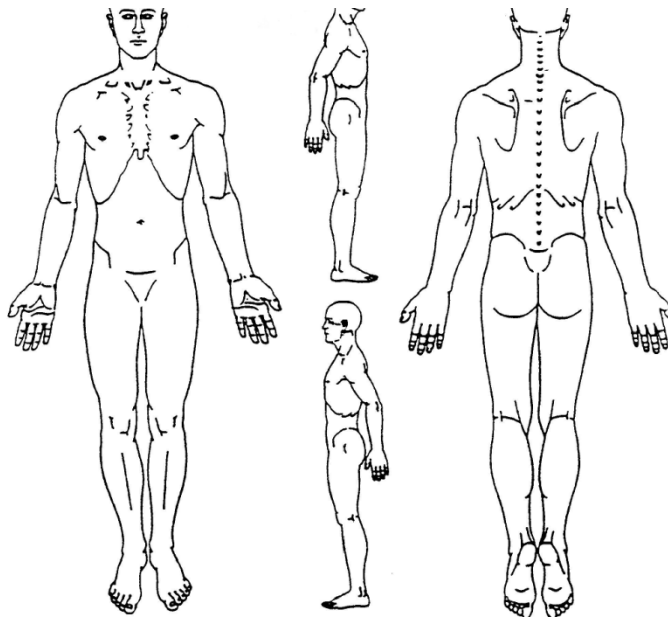
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Primary Problem Form – Cervical Spine

Briefly describe your symptoms

If you have pain, or if pain was previously part of the problem, please indicate the location



Do you have **numbness** and/or **tingling**? Yes No

Do you have **weakness** or **loss of strength**? Yes No

How long have you had these symptoms? _____

Did the symptoms start as a result of an accident or incident? Yes No

If so, please describe _____

What makes you pain or other symptoms worse? (Please check all that apply)

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Activity |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Time of day | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Work | |

Please Complete Both Sides!

What other treatments have you tried for this problem? (Please check all that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Ice/Heat | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Anti-inflammatory medications
(e.g. aspirin, advil, ibuprofen, aleve, naproxen) | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Narcotic pain medications | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy | |

Have you missed work because of these symptoms? Yes No

Please refer to the pain scale below

What is the **current** level of your pain? _____

What has been the **maximum** level of your pain? _____

Subjective Pain Scale		
	0	No pain. Feeling perfectly normal.
Minor Able to adapt to pain	1 Very Mild	Very light barely noticeable pain
	2 Discomforting	Minor pain, like lightly pinching the fold of skin
	3 Tolerable	Very noticeable pain, like a doctor giving you an injection
Moderate Interferes with many activities.	4 Distressing	Strong, deep pain, like an average toothache
	5 Very Distressing	Strong, deep, piercing pain, such as a sprained ankle
	6 Intense	Strong, deep, piercing pain like several bee stings
Severe Patient is disabled and unable to function independently.	7 Very Intense	Comparable to an average migraine headache
	8 Utterly Horrible	Comparable to childbirth or a real bad migraine headache
	9 Excruciating Unbearable	Pain so intense you cannot tolerate it and demand pain killers
	10 Unimaginable Unspeakable	Pain so intense you will go unconscious shortly.

Please Complete Both Sides!

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