Spinal (Neck) Evaluation:
Guidelines for the use of this form follows:

1) Basic information is entered as indicated on the form including patient's name, MPI#, Division, Unit, Date of Admission, Date of Birth, and Age.

2) Treating Diagnoses/Chief Complaint – indicate the reason for referral.

3) Hx of Neck Problems – Prior Neck Surgeries. Include all injuries, diagnosis, surgeries pertaining to patients' spine.

4) Past Medical History – Axis III Diagnoses.

5) Anticipated Occupation Upon Discharge – indicate what job the patient will be returning to and include any important functional tasks which will need to be performed.

6) Hand Dominance: indicate whether patient is Right or Left-handed.

7) Height – indicate patient's height in inches. Weight – indicate patient's weight in pounds. BMI – indicate BMI from chart.

8) Radiculopathy – indicate whether pain is reduced with arm overhead (C5/C6) or arm cradled (C7).

9) Posture – indicate whether patient demonstrates forward head, lateral tilt to left or right, Rounded shoulders or protracted scapulae.

10) Range of Motion (ROM) – indicate whether ROM (actively and passively is limited or within normal limits (WNL). Measure available ROM (actively and passively) in cervical spine using goniometer or tape measure and note the quality of the end feel. Also, indicate any limitations in shoulder ROM.

11) Strength – indicate whether the quality of each movement listed is weak or strong and whether painful or pain free. IP = Interphangeal Joint. Ext = Extension. Flex = Flexion.

12) Reflexes – indicate the response to each reflex test listed. Note any additional special tests and results of that test in the area provided.

13) Sensation – indicate whether light touch sensation is intact of decreased in areas noted.

14) Pain Description – Fill in adjacent diagram of areas of pain using the key to denote stabbing type, numbness, pins and needles, aching and burning pain sensations. Indicate the location of the pain, the severity of the pain (noting present, best and worst over time), eliciting factors, relieving factors, aggravating factors, and length of pain sensation. Indicate the nature of the pain from the list provided. Note the duration of the pain and the areas where

the pain may radiate to. Note if the pain follows dermatome distributions or peripheral nerve distributions.

15) Palpation – indicate any abnormal findings to in the musculature, bony structures, skin or alignment.

16) Assessment- A summary of findings from the evaluation should be written with emphasis on strengths and weaknesses. For re-assessments response to treatment should be included.

17) Recommendation s- Patient needs will be identified and priorities recommended.

19) Goals - Check off appropriate goal from the choices listed or describe another objective goal next to "other."

20) Treatment Plan - Check off appropriate treatments from the choices listed or describe another treatment next to "other."

21) Frequency of Treatment - Write recommended number of times patient will be seen per week and include which days of the week the patient will be seen.

22) Location of Treatment – Indicate the location where the treatment will be taking place, i.e. Page Hall PT, Merritt Hall Pool, on unit, etc.

23) Assessment and Treatment Plan discussed with Patient-Indicate yes or no. Indicate yes or no. If no, explain why.

23) The evaluating therapist should sign and date the evaluation.