

McLaren Print System Order

Order No: 59580
 Order Date: 2021-01-12
 User: Melissa Jordan
 Phone: 810-342-2642

Ship Location: McLaren Flint - 1 Central Quality Management Attn: Melissa
 401 Ballenger Highway
 Flint, MI 48532

Forms

Quantity: 100
 Paragon Dept No: 91650
 Dept Name: Quality Management
 Company Number: 60

Order Total Price: 16.76

Item Number: ﻿﻿M-34130
 Item Description: Form Cerv Baseline Questionnaire
 Revision Date: 2020
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: Staple (Upper Left)
 Drill: None
 Misc Info: ds; black & white; 4 pages; bond

MSK Data Registry
Cervical Baseline
Patient Questionnaire

Patient Name: _____ MRN: _____ Registry ID: _____

Date of Questionnaire: _____

We ask that you please complete this form as fully and accurately as possible. Some questions may be difficult, but we ask that you answer them to the best of your ability. Please be sure to follow the directions in each section. Clearly print responses and mark boxes where needed.

Thank you for your time filling out this questionnaire, your answers will help us to provide the best possible spine care.

Neck & Arm Pain Scale

Please describe your neck and arm pain when off your pain medication. Please rate your neck pain and arm pain on a scale of 0 to 10, where zero (0) would mean "no pain" and a ten (10) would mean "worst pain imaginable."

For example, describe your pain when you are off your medication, after your pain medication has worn off, when you are due to take your next pill, that is please describe how your pain would feel if you were not on pain medication.

Please rate your neck pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your arm pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Overall Quality of Life (OQ-10) © EuroQol Research Foundation.
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By marking one box in each group below, please indicate which statement best describes your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

Spec Info: Physical Function

Please respond to each question or statement by marking one box per row.

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MSK-0000
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 August 2018