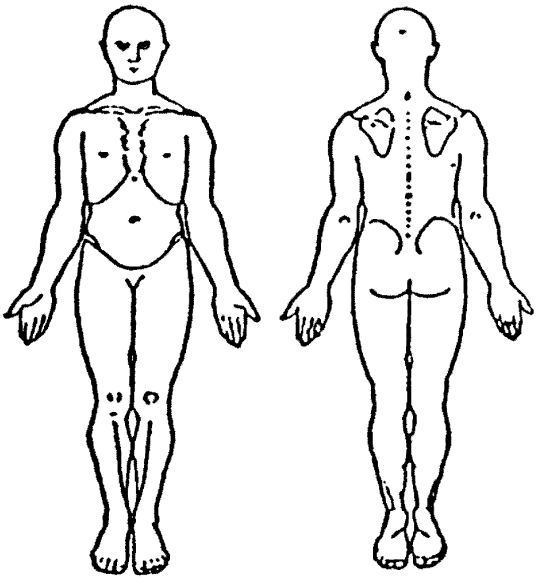
THE McKENZIE INSTITUTE
CERVICAL SPINE ASSESSMENT



Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____

Present Symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ no apparent reason

Symptoms at onset: *neck / arm / forearm / head* _____

Constant symptoms: *neck/arm/forearm/head* _____ Intermittent symptoms: *neck/arm/forearm/head* _____

Worse *bending* *sitting* *turning* *lying / rising*

am / as the day progresses / pm *when still / on the move*

other _____

Better *bending* *sitting* *turning* *lying*

am / as the day progresses / pm *when still / on the move*

other _____

Disturbed Sleep *yes / no* Sleeping postures: *prone / sup / side R / L* Pillows: _____

_____

Previous spinal history _____

_____

Previous treatments _____

_____

SPECIFIC QUESTIONS

Dizziness / tinnitus / nausea / vision / speech _____ Gait / Upper Limbs: *normal / abnormal*

Medications: _____

General health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations / beliefs: _____

_____

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EXAMINATION

POSTURAL OBSERVATION

Sitting: *erect / neutral / slump* Protruded head: *yes / no* Lateral deviation: *right / left / nil*

Change of posture: *better / worse / no effect* _____ Lateral deviation relevant: *yes / no*

Other observations / functional baselines: _____

NEUROLOGICAL

Motor deficit _____ Reflexes _____

Sensory deficit _____ Neurodynamic tests _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Protrusion					
Flexion					
Retraction					
Extension					

	Maj	Mod	Min	Nil	Symptoms
Lateral flexion R					
Lateral flexion L					
Rotation R					
Rotation L					

TEST MOVEMENTS **Describe effect on present pain – During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptoms during testing	Symptoms after testing	Mechanical Response	
			Effect - ↑or ↓ROM or key functional test	No effect
Pretest symptoms sitting				
PRO				
Rep PRO				
RET				
Rep RET				
RET EXT				
Rep RET EXT				
Pretest symptoms lying				
RET				
Rep RET				
RET EXT				
Rep RET EXT				
Pretest symptoms				
LF - R				
Rep LF - R				
LF - L				
Rep LF - L				
ROT - R				
Rep ROT - R				
ROT - L				
Rep ROT - L				
FLEX				
Rep FLEX				
Other movements				

STATIC TESTS Pro / Ret / Flex / Other _____ **OTHER TESTS** _____

PROVISIONAL CLASSIFICATION

Derangement Central or symmetrical Unilateral or asymmetrical above elbow Unilateral or asymmetrical below elbow

Directional Preference: _____

Dysfunction: Direction _____ **Postura**l **OTHER** subgroup: _____

Drivers of pain and / or disability: Contextual Cognitive Emotional Comorbidities

_____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

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