SPINE AND SPORTS CENTER
OF CHICAGO

**PATIENT INFORMATION** **Date _____/_____/_____**

Patient Name (last, first) _____ Preferred Name _____

Home Phone (_____) _____ Work Phone # (_____) _____ Cell Phone (_____) _____

Social Security #_____ E-Mail Address _____

Address_____ City_____ State_____ Zip Code_____

Date of Birth _____/_____/_____ Age____ Sex: M F Height_____ Weight ____ Patient Employer _____

Work Address_____ City_____ State_____ Zip Code_____

Occupation / Job Description _____

Marital Status (circle one): Single / Married / Widowed / Divorced / Separated / Domestic Partner / Other: _____

*How did you hear about Spine & Sports Center of Chicago?* _____

Emergency Contact _____ Relationship _____ Phone # (_____) _____

**Note:** (Only fill out this section if the patient is different from the insured) Insured Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Home Phone #: _____ Date of Birth: ___/___/_____

Insured Employer: _____ Work Phone: _____

Work Address: City: State: Zip Code:

## Review of Systems: *Please write in a number .1 – PRESENTLY HAVE 2 – PREVIOUSLY HAD 3 – RELATED TO ACCIDENT*

**GENERAL**
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep Loss
___Weight Loss/Gain
___Nervousness/Depression
___Neuralgia
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

**EYE, EARS, NOSE THROAT**
___Asthma
___Colds
___Sore Throat
___Deafness
___Dental decay
___Ear aches/ringing in ear
___Ear Discharge
___Sinus Infection
___Enlarged Thyroid
___Enlarged Glands
___Nose Bleeds
___Vision problems
___Far sighted
___Near Sighted
___Hoarseness
___Nasal Obstruction

**MUSCULOSKELETAL**
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___low back pain
___lumbago
___neck pain/stiffness
___shoulder blade pain

**PAIN OR NUMBNESS IN:**
___ shoulders
___ arms
___ elbows
___ hands
___ Hips
___ legs
___ knees
___ ankles
___ feet
___poor posture
___sciatica
___spinal curvature

**GENITOR-URINARY**
___bedwetting
___blood in urine
___frequent urination
___inability to control bladder
___kidney infection or stones
___Painful urination
___prostate trouble
___pus in urine
___painful menstruation
___hot flashes
___irregular cycle
__ lumps in breasts

**CARDIOVASCULAR**
___Hardening of arteries
___high blood pressure
___low blood pressure
___pain over heart
___poor circulation
___rapid heart beat
___slow heart beat
___swelling of ankles

**RESPIRATORY**
___chest pain
___chronic cough
___difficult breathing
___spitting up blood
___spitting up phlegm
___wheezing

**GASTROINTESTINAL**
___belching or gas
___colitis
___colon trouble
___constipation
___diarrhea
__difficult digestion
___distention of abdomen
___excessive hunger
___heartburn/reflux
___gall bladder trouble
___hemorrhoids
___intestinal worms
___jaundice
___liver trouble
___nausea
___Pain over stomach
___Vomiting
___Vomiting blood

**DOCTOR ONLY:**

_____

_____

_____

_____

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Patient Name: _____ Date: _____/_____/_____

**Current Medication: (Include all vitamins, herbal supplements, and over-the-counter medications.)**

1._____ 5._____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

**Allergies (medication, food, other substance**) Please list and state the reaction you had:

_____

_____

**Hospitalizations / Surgeries** (please list procedures, dates and locations): _____

_____

_____

**Imaging (**X-RAYS, MRI'S, ULTRASOUNDS, etc.)_____

_____

**Previous Injuries** (sprains, fractures, auto or other accidents, etc.) _____

_____

**Family History:** Check any diseases which your relatives have had (if known):

| Relatives | Arthritis | Cancer | Diabetes | Heart Disease/Stroke | Kidney Disease | Neurological Disease | Thyroid Disease | Deceased |
|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | |
| Mother | | | | | | | | |
| Brother | | | | | | | | |
| Sister | | | | | | | | |
| Maternal Grandparents | | | | | | | | |
| Paternal Grandparents | | | | | | | | |

**DOCTOR ONLY:** _____

_____

_____

**Personal Habits** – Please answer honestly. *All information is confidential.*

Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

| | 1 | 2 | 3 | 4 | 5 | Elaborate |
|---|---|---|---|---|---|---|
| Exercise Regularly (3-4 x week) | | | | | | |
| Wear Seat Belts | | | | | | |
| Recreational Drugs | | | | | | |
| Drink Alcohol | | | | | | |
| Smoke | | | | | | |
| Chew Tobacco | | | | | | |
| Experience Stress | | | | | | |
| Other | | | | | | |

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Patient Name: _____ Date: _____/_____/_____

**Women Only:**

Menstrual Periods: Age of Onset: ___ Regular? Yes ☐ No ☐ Length of Period: _____

Date last Period Began: ___/___/____ Average Cycle Length: _____

Difficulty with Periods: Yes ☐ No ☐ Specify: _____

Age at Menopause (if applicable): _____ Date of last Pap Smear/Pelvic Exam? ____/____/_____

Number of Children: Born Alive____ Cesarean_____ Premature_____ Stillborn____ Miscarriages _____

Describe Pregnancy or Other Complications (if applicable):_____

_____

**Nutritional Information:**

Please indicate what you eat in a typical week: Breakfast ☐ Lunch ☐ Dinner ☐ # Snacks _____

Indicate the estimated number of servings of each of the following items consumed in a **typical week.**

| | | | | |
|---|---|---|---|---|
| ___Eggs | ___Red Meat | ___Nuts/Seeds | ___Butter | ___spicy food |
| ___Cheese | ___Pork/Ham/Bacon | ___Nut Butter | ___Margarine | ___junk food |
| ___Milk (Type_____) | ___Chicken/Turkey | ___Fruits | ___Olive Oil | ___fast food |
| ___Yogurt | ___Fish | ___Vegetables | ___Canola Oil | ___desserts |
| ___Sour Cream | ___Beans | ___Rice/Pasta | ___Corn Oil | ____other_____ |
| ___Ice Cream | ___Tofu/Soy | ___Bread/Cereal | ___Sunflower | ____other_____ |
| ___Other _____ | ___Lunch Meats | ___Other_____ | ___Other Oil_____ | ____other_____ |

Any foods not listed and consumed regularly: _____

Indicate the estimated number of servings (6-8oz cups) of the following consumed in a **typical day.**

| | | |
|---|---|---|
| ___Caffeinated Coffee | ___Green Tea | ___Water |
| ___Decaffeinated Coffee | ___Regular Soft Drinks | ___Fruit Juice |
| ___Regular Tea | ___Diet Soft Drinks | ___Sports Drinks |
| ___Herbal Tea | ___Diet Drinks/Aids | ___Other |

Any drinks not listed and consumed regularly: _____

On a scale of 0-10 (10 being extremely healthy), how healthful do you rate your diet? ___/10

If you try to follow a specific diet, please describe the diet and why you follow this type of diet: _____

_____

If you would like to have a nutritional consultation, please indicate any specific goals and/or questions: _____

_____

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance: _____

_____

What do you hope to enjoy better when you regain your health? _____

**DOCTOR ONLY:** _____

_____

_____

_____

_____

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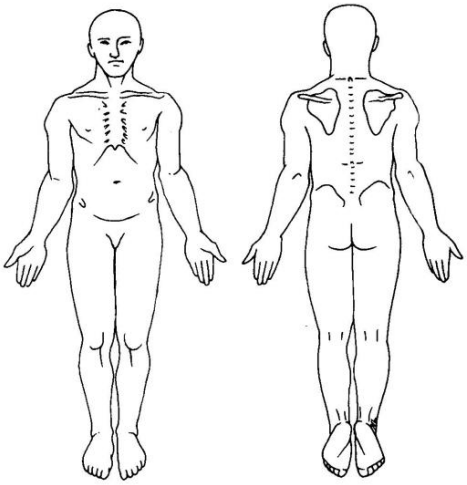
Patient Name: _____ Date: _____/_____/_____

**Mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.**

| Numbness | Pins & Needles | Burning | Aching | Sharp / Stabbing |
|---|---|---|---|---|
| +++++ | 00000 | xxxxx | ***** | / / / / / |



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY
1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST
1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY
1 2 3 4 5 6 7 8 9 10

**DOCTOR ONLY:** _____