SPINE AND SPORTS CENTER
OF CHICAGO

NEW & EXISTING PATIENT
HEADACHE APPOINTMENT PACKET

NEW PATIENTS:
Please fill in ALL THE FORMS in this packet and bring them with you for your first visit.

EXISTING PATIENTS:
Please go to page 7 and fill in all remaining forms. Bring them with you when you return to the office.

**WE CANNOT ACCEPT FORMS VIA FAX.
PLEASE REMEMBER TO BRING THESE FORMS WITH YOU FOR YOUR SCHEDULED APPOINTMENT.**

Questions? Please call us at (312) 846-6647

SPINE AND SPORTS CENTER OF CHICAGO

NEW PATIENTS ONLY

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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SPINE AND SPORTS CENTER OF CHICAGO

NEW PATIENTS ONLY

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: ____

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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						

SPINE AND SPORTS CENTER OF CHICAGO

NEW PATIENTS ONLY

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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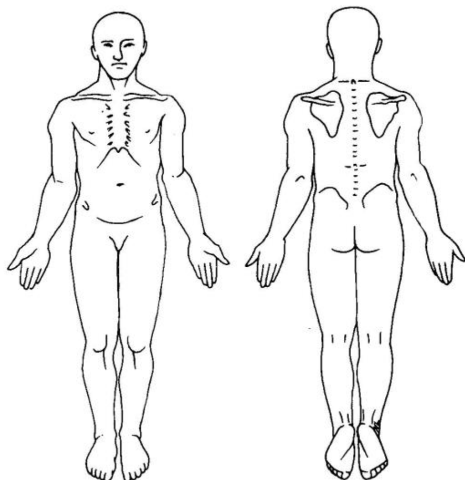
SPINE AND SPORTS CENTER OF CHICAGO

NEW PATIENTS ONLY

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: ____

Spine & Sports Center of Chicago, Ltd, 430 W Erie St., Suite 403, Chicago, IL 60661 Telephone: 312-846-6647 Fax: 312-846-6817

Insurance Verification

Please call your insurance company to verify your benefits prior to your first visit at Spine & Sports Center of Chicago. We are "In-Network" with BlueCross Blue Shield PPO only; all other insurance carriers are "Out-of-Network". Make sure you state that when you call.

Patient Name: ____ **Date of Birth:** ________/______/______

Insurance ID: ____ **Group #** ______________________________

Insurance Company ___________________________________

Primary Card Holder Patient Y / N: if no who is _________________________________

Relationship to: ____________________ **Date of Birth:** ________/______/______

Date and Time Called: ____________________________ Reference #: ___________________________________

Please ask the following questions:

Policy Effective Date___________________________

Deductable per Calendar Year ____________________ Amount Met _________________

Policy year begins on January 1st? **Yes No** If no, when? _________________________

Is there a pre-existing condition on this policy **Yes No** If yes, when does it expire ____/______/______

Does this plan require pre authorization / pre notification / or pre certification **Yes No**

How is an office visit covered?

Coinsurance %: _________ Copay: ________ Max Benefit Amount $__________ Max # of Visits/Year_____________

How is chiropractic care covered?

Coinsurance%: _________ Copay: ________ Max Benefit Amount $__________ Max # of Visits/Year_____________

Out of pocket $_________

How is physical therapy covered?

Coinsurance%: _________ Copay: ________ Max Benefit Amount $ __________ Max # of Visits/Year_____________

Out of pocket $_________

How is acupuncture covered? Does the doctor have to be a licensed MD Yes No

Coinsurance%: _________ Copay: ________ Max Benefit Amount $__________ Max # of Visits/Year_____________

Out of pocket $_________

How are codes 97140 and 97124 covered?

Coinsurance%: _________ Copay: ________ Max Benefit Amount $__________ Max # of Visits/Year _____________

SPINE AND SPORTS CENTER OF CHICAGO

NAME ______________________________ **Primary Complaint :** ____________________________

1. Please indicate your usual level of pain during the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst possible pain**

2. Does pain, numbness, tingling or weakness <u>extend</u> into your leg (from the low back) &/or arm (from the neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 **All of the time**

3. How would you rate your general health? (10-x)

Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

4. If you had to spend the rest of your life with your <u>condition as it is right now</u>, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 **Terrible**

5. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during the past week:

Not at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely anxious**

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during the past week:

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 **I can't reduce it at all**

7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in the past week:

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely depressed**

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in <u>six months</u>?

Very certain 0 1 2 3 4 5 6 7 8 9 10 **Not certain at all**

9. I can do light work for an hour?

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

10. I can sleep at night

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

12. Physical activity makes my pain worse?

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

13. I should not do my normal activities including work with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

Patient Signature: ____________________________ **Date:** ____________

HEADACHE DISABILITY INDEX

Patient Name ______________________________ Date ______________

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	____	____	E1.	Because of my headaches I feel handicapped.
____	____	____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	E3.	No one understands the effect my headaches have on my life.
____	____	____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	E5.	My headaches make me angry.
____	____	____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	F7.	Because of my headaches I am less likely to socialize.
____	____	____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	E9.	My headaches are so bad that I feel that I am going to go insane.
____	____	____	E10.	My outlook on the world is affected by my headaches.
____	____	____	E11.	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	E12.	I feel desperate because of my headaches.
____	____	____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	E14.	My headaches place stress on my relationships with family or friends.
____	____	____	F15.	I avoid being around people when I have a headache.
____	____	____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	F17.	I am unable to think clearly because of my headaches.
____	____	____	F18.	I get tense (eg, muscle tension) because of my headaches.
____	____	____	F19.	I do not enjoy social gatherings because of my headaches.
____	____	____	E20.	I feel irritable because of my headaches.
____	____	____	F21.	I avoid traveling because of my headaches.
____	____	____	E22.	My headaches make me feel confused.
____	____	____	E23.	My headaches make me feel frustrated.
____	____	____	F24.	I find it difficult to read because of my headaches.
____	____	____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: ______________________________

____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.

NAME DATE

Cervical Positional Tolerance Questionnaire (CPTQ)

Instructions: Read question 1 and then proceed to the symptoms keeping in mind that the symptoms relate to the question. Read each of the symptoms in the right hand column and the patient is instructed to answer YES, NO, SOMETIMES for each symptom. Proceed to questions 2 and 3 in the same manner.

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1. Do you avoid looking up as if into a high cabinet shelf because doing so causes:

- Visual Problems or Dizziness YES/NO/SOMETIMES
- Sudden Drop to the Floor YES/NO/SOMETIMES
- Unsteadiness YES/NO/SOMETIMES
- Extremity Weakness YES/NO/SOMETIMES
- Confusion YES/NO/SOMETIMES
- Headaches YES/NO/SOMETIMES
- Hearing Loss YES/NO/SOMETIMES
- Loss of Consciousness YES/NO/SOMETIMES
- Arm or Leg Numbness YES/NO/SOMETIMES
- Problems with Speech YES/NO/SOMETIMES
- Ringing in the Ear YES/NO/SOMETIMES
- Numbness around Mouth YES/NO/SOMETIMES

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2. Do you avoid looking over your left shoulder as if backing up your car because doing so causes:

- Visual Problems or Dizziness YES/NO/SOMETIMES
- Sudden Drop to the Floor YES/NO/SOMETIMES

- Unsteadiness YES/NO/SOMETIMES
- Extremity Weakness YES/NO/SOMETIMES
- Confusion YES/NO/SOMETIMES
- Headaches YES/NO/SOMETIMES
- Hearing Loss YES/NO/SOMETIMES
- Loss of Consciousness YES/NO/SOMETIMES
- Arm or Leg Numbness YES/NO/SOMETIMES
- Problems with Speech YES/NO/SOMETIMES
- Ringing in the Ear YES/NO/SOMETIMES
- Numbness around Mouth YES/NO/SOMETIMES

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3. Do you avoid looking over your right shoulder as if backing up your car because doing so causes:

- Visual Problems or Dizziness YES/NO/SOMETIMES
- Sudden Drop to the Floor YES/NO/SOMETIMES
- Unsteadiness YES/NO/SOMETIMES
- Extremity Weakness YES/NO/SOMETIMES
- Confusion YES/NO/SOMETIMES
- Headaches YES/NO/SOMETIMES
- Hearing Loss YES/NO/SOMETIMES
- Loss of Consciousness YES/NO/SOMETIMES
- Arm or Leg Numbness YES/NO/SOMETIMES
- Problems with Speech YES/NO/SOMETIMES
- Ringing in the Ear YES/NO/SOMETIMES
- Numbness around Mouth YES/NO/SOMETIMES

SCORE (Total # YES Responses + Total # Sometimes Responses) Scores ≥ 1 constitutes a positive CPTQ)

SPINE AND SPORTS CENTER
OF CHICAGO

Patient Name________________ Date:______________

- **Patient Specific Functional Scale (PSFS):**
"Identify **3** activities that you are not able to do or have difficulty with as a result of your problem.
(Write the activity that you are having trouble with in the space provided below (e.g. running, sitting, standing, etc.) Then circle the number that corresponds to that activity.

1.) How difficult is __________ for you?
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

2.) How difficult is __________ for you?
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

3.) How difficult is __________ for you?
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

- **Pain Limitation:** "Over the past 24 hours, how much has your pain limited you from performing any of your normal daily activities?"

0 1 2 3 4 5 6 7 8 9 10
(Activities severely limited) (Activities not limited)

- **Pain Intensity:** "Over the past 24 hours, how bad has your pain been?"

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Pain as bad as it can be)

SPINE AND SPORTS CENTER OF CHICAGO

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration/

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Patient name ____________________ Patient signature ____________________ Date ______

SPINE AND SPORTS CENTER
OF CHICAGO

THANK YOU!

You have successfully completed the information we need. Please bring these forms with you when you come to the office for your visit.