SPINE AND SPORTS CENTER
OF CHICAGO

NEW & EXISTING PATIENT
HIP PAIN 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 _____________

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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 extend 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 condition as it is right now, 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 six **months**?

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:** ______________

SPINE AND SPORTS CENTER
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REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back/leg pain is affecting your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that best applies to you today. 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
B. The pain is mild
C. The pain comes and goes and is moderate
D. The pain does not vary much and is moderate
E. The pain comes and goes and is severe
F. The pain does not vary much and is severe

SECTION 2 - Personal Care

A I would not have to change my way of washing or dressing to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights from any height.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (eg. on a table)
E Pain prevents me from lifting heavy weights off the floor, but I can manage medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I can walk as long as I want without getting pain.
B Walking gives me pain which does not increase with time.
C Walking gives me pain which I can relieve by varying my pace.
D I get pain only when I walk long distances.
E I get pain when I walk short distances.
F I avoid walking because it gives me pain straight away.

SECTION 5 - Sitting

A I can sit in any chair as long as I like without pain.
B I can sit in some types of chairs as long as I like without getting pain.
C I get pain only when I get out of some seats.
D I get pain after sitting in most seats.
E I get pain soon on sitting in most seats.
F Sitting in most seats gives me pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B Standing eventually causes some pain, but it does not increase with time.
C Standing eventually gives me pain which I can relieve by shifting my weight.
D Standing eventually gives me pain which I can not relieve by shifting my weight.
E I get pain soon on standing.
F I avoid standing because I get pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get some pain in bed but it does not disturb my sleep.
C I get some pain in bed which sometimes disturbs my sleep.
D I get pain in bed which often disturbs my sleep.
E I get pain in bed which always disturbs my sleep.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the pain.
C Pain has no significant effect on my social life apart from limiting more energetic interests, (e.g., dancing)
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A My pain has gone.
B My pain is rapidly getting better.
C My pain varies but is slowly getting better.
D My pain is getting neither better nor worse.
E My pain is slowly worsening.
F My pain is rapidly worsening.

Patient name ______________________________ Patient signature __________________________ Date ______

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)

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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.

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