SPINE AND SPORTS CENTER
OF CHICAGO

NEW & EXISTING PATIENT
JAW 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:

_____

_____

_____

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: _____

_____

_____

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: _____

_____

_____

_____

_____

SPINE AND SPORTS CENTER
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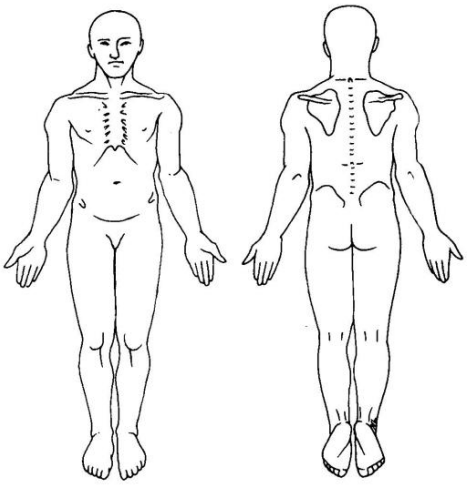
NEW PATIENTS ONLY

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 _____

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: _____

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)

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)

Form C-15a

TMD DISABILITY INDEX (STEIGERWALD/MAHER)

NAME _____ M /F _____ AGE_____ DATE_____ SCORE _____

Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

1. Communication (talking)

( ) I can talk as much as I want without pain, fatigue or discomfort.
( ) I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
( ) I can't talk as much as I want because of pain, fatigue and/or discomfort.
( ) I can't talk much at all because of pain, fatigue and/or discomfort.
( ) Pain prevents me from talking at all.

2. Normal living activities (brushing teeth/flossing).

( ) I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
( ) I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
( ) I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
( ) I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
( ) I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

3. Normal living activities (eating, chewing).

( ) I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
( ) I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
( ) I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
( ) I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
( ) I must stay on a liquid diet because of pain and/or restricted opening.

4. Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.).

( ) I am enjoying a normal social life and/or recreational activities without restriction.
( ) I participate in normal social life and/or recreational activities but pain/discomfort is increased.
( ) The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
( ) I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
( ) I have practically no social life because of pain.

5. Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).

( ) I can yawn in a normal fashion, painlessly.
( ) I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
( ) I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
( ) Yawning and opening my mouth wide are somewhat restricted by pain.
( ) I cannot yawn or open my month more than two finger widths (28-32 cm) or, if I can, it always causes greater than moderate pain.

5. Sexual function (including kissing, hugging and any and all sexual activities to which you are accustomed).

( ) I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
( ) I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.
( ) I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
( ) I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
( ) I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

7. Sleep (restful, nocturnal sleep pattern).

( ) I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
( ) I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.
( ) I fail to realize 6 hours restful sleep even with the use of pills.
( ) I fail to realize 4 hours restful sleep even with the use of pills.
( ) I fail to realize 2 hours restful sleep even with the use of pills.

8. Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g., splints, mouthpieces), ice/heat, etc.

( ) I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
( ) I can completely control my pain with some form of treatment.
( ) I get partial, but significant, relief through some form of treatment.
( ) I don't get "a lot of" relief from any form of treatment.
( ) There is no form of treatment that helps enough to make me want to continue.

9. Tinnitus, or ringing in the ear(s).

( ) I do not experience ringing in my ear(s).
( ) I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
( ) I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
( ) I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
( ) I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

10. Dizziness (lightheaded, spinning and/or balance disturbance).

( ) I do not experience dizziness.
( ) I experience dizziness, but it does not interfere with my daily activities.
( ) I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
( ) I experience dizziness which causes a marked impairment in the performance of my daily activities.
( ) I experience dizziness which is incapacitating.

NAME _____ **M /F** _____ **AGE**_____ **DATE**_____ **SCORE**_____

Steigerwald DP, Maher JH. The Steigerwald/Maher TMD Disability Questionnaire. Today's Chiro 1997; 26:8

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.

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