



SPINE AND SPORTS CENTER
OF CHICAGO

NEW & EXISTING PATIENT LOWER BACK 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



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:

Blank lines for doctor notes

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						



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 & 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: _____



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.**

<p>SECTION 1 - Pain Intensity</p> <p>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</p>	<p>SECTION 6 - Standing</p> <p>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.</p>
<p>SECTION 2 - Personal Care</p> <p>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.</p>	<p>SECTION 7 - Sleeping</p> <p>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.</p>
<p>SECTION 3 - Lifting</p> <p>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.</p>	<p>SECTION 8 - Social Life</p> <p>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.</p>
<p>SECTION 4 - Walking</p> <p>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.</p>	<p>SECTION 9 - Traveling</p> <p>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.</p>
<p>SECTION 5 - Sitting</p> <p>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.</p>	<p>SECTION 10 - Changing Degree of Pain</p> <p>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.</p>

Patient name _____ Patient signature _____ Date _____



Name: _____

Date: ____ / ____ / ____
mm dd yy

Here are some of the things other patients have told us about their pain. For each statement please circle the number from 0 to 6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree	0	1	2	3	4	5	6	Completely Agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6		
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6		
3. Physical activity might harm my back.	0	1	2	3	4	5	6		
4. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6		
5. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6		

The following statements are about how your normal work affects or would affect your back pain.

	Completely Disagree	0	1	2	3	4	5	6	Completely Agree
6. My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6		
7. My work aggravated my pain.	0	1	2	3	4	5	6		
8. I have a claim for compensation for my pain.	0	1	2	3	4	5	6		
9. My work is too heavy for me.	0	1	2	3	4	5	6		
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6		
11. My work might harm my back.	0	1	2	3	4	5	6		
12. I should not do my regular work with my present pain.	0	1	2	3	4	5	6		
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6		
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6		
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6		
16. I do not think that I will ever be able to go back to that work.	0	1	2	3	4	5	6		



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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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