



SPINE AND SPORTS CENTER  
OF CHICAGO

# NEW & EXISTING PATIENT MID 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
\_\_\_ BURSTITIS
\_\_\_ 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's 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:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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

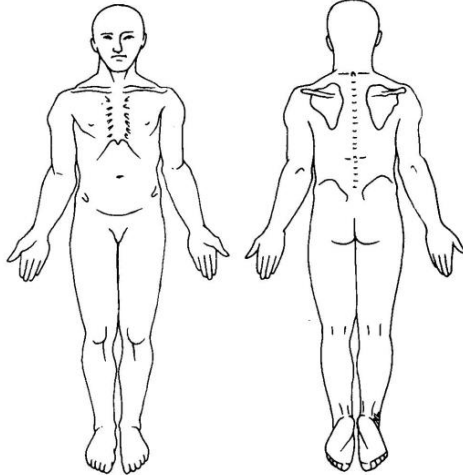
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xxxxx

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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: \_\_\_\_\_

Multiple horizontal lines for doctor notes.

**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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)



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