CHICAGO
SPORTS & SPINE
PAIN MANAGEMENT PHYSICIANS

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/_____

Street Address _____ City, State _____ Zip _____

Home Phone **( )** _____ Work **( )** _____ Cell **( )** _____

Email Address _____

Social Security Number _____ **-** _____**-**_____

Patient Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

In case of Emergency, please contact:

Name _____ Phone**: ( )** _____

Relationship to Patient _____

Referring Physician _____ Phone: **( )** _____

Primary Care Physician _____ Phone: **( )** _____

How did you hear about Chicago Sports and Spine?

☐ Family/Friend _____ ☐ Physician _____

☐ Insurance ☐ Website _____ ☐ Other _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

Insured's Name: _____ Relation to Patient _____ Date of Birth: ___/___/____

Secondary Insurance _____ ID# _____

Insured's Name: _____ Relation to Patient _____ Date of Birth: ___/___/____

Person Responsible for any balances _____

Address (If different from patient) _____

WORMAN'S COMP/LIABILITY

If today's exam applies to a Workman's Comp case or Liability case, please fill this section out in its entirety.

WORKMAN'S COMP:

Date of Injury _____/_____/_____ Claim # _____ Contact _____

Employer _____ Phone # _____

Address _____ City _____ State _____ Zip _____

W/C Insurance _____ Phone # _____

Address _____ City _____ State _____ Zip _____

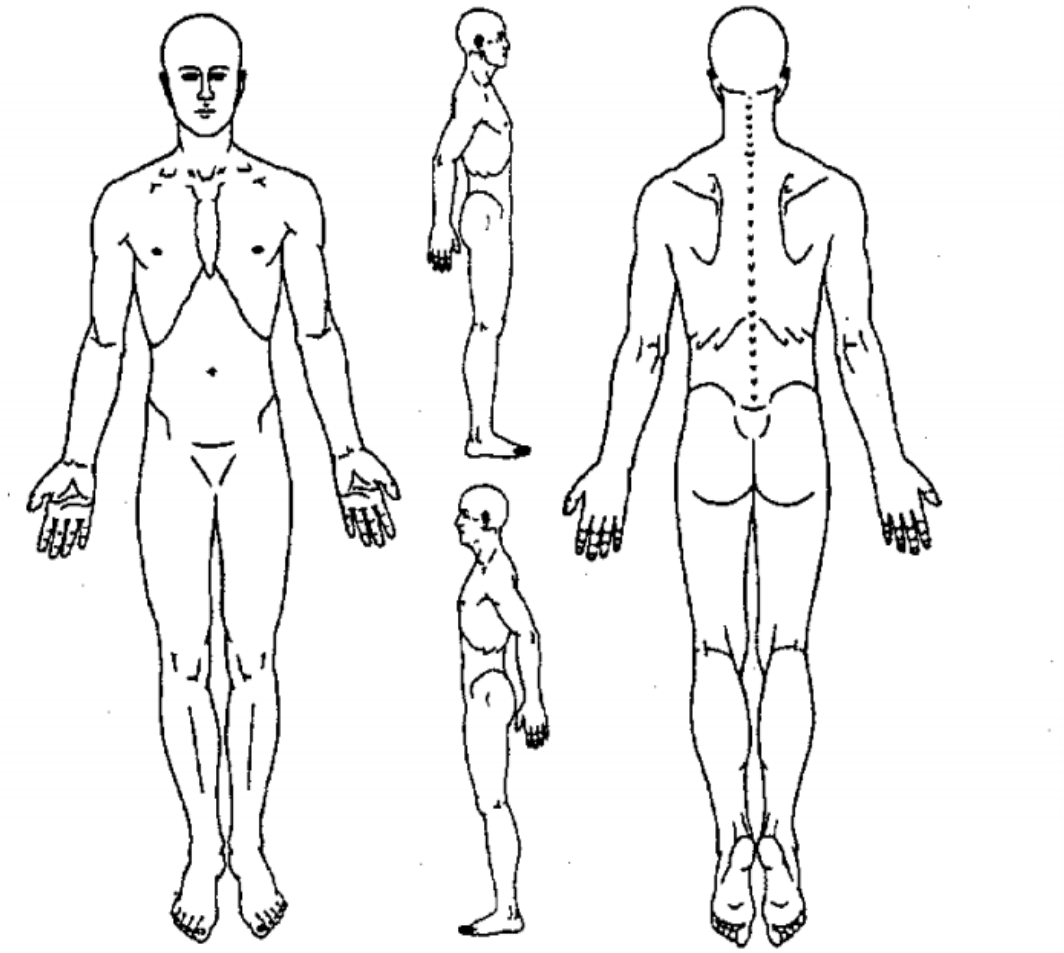
LIABILITY:

Attorney Name _____ Phone # _____ Date of Injury ____/____/_____

Address _____ City _____ State _____ Zip _____

PAIN CLINIC INITIAL EVALUATION FORM

On the picture below, mark the areas on your body where you are currently experiencing pain or other symptoms.



How would you describe your pain?

☐ Aching ☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Stabbing ☐ Other _____

Approximately when did your pain start? _____

Is your pain a result of an injury? ☐ **Yes** ☐ **No** If yes. What was the date of injury? ____/____/____

Please explain:

_____

Pain is: ☐ **Constant** ☐ **Intermittent**

What increases your pain? _____

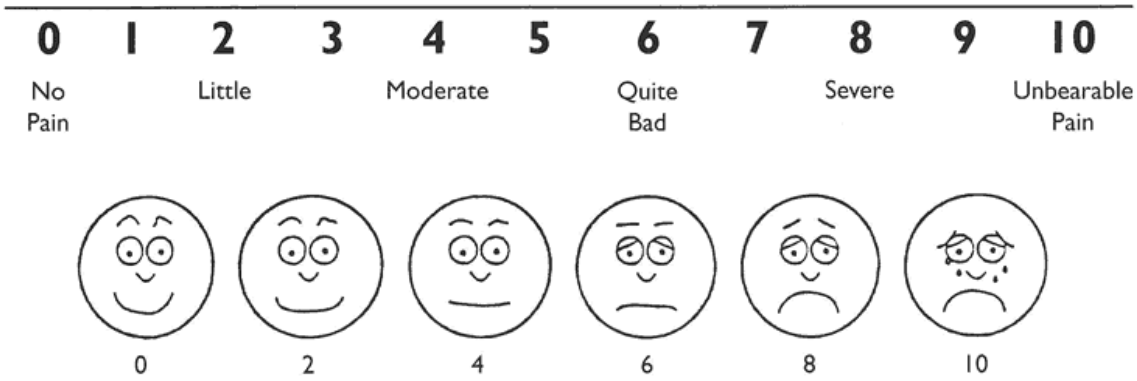
What decreases your pain? _____

Has your pain gotten worse with time? ☐ **Yes** ☐ **No**

Do you have difficulty sleeping because of the pain? ☐ **Yes** ☐ **No**

Do you have any bowl or bladder problems? ☐ **Yes** ☐ **No**

Using the pain scale below, **rate your pain.**



As of today, what have you done to help relieve your pain? (Check all that apply.)

☐ Physical Therapy ☐ TENS Unit

☐ Chiropractor ☐ Ice

☐ Massage Therapy ☐ Heat

☐ Medications ☐ Other:

Have you seen any pain physician for this problem in the past? ☐ **Yes** ☐ **No**

Name: _____

Have you ever had spine surgery? ☐ **Yes** ☐ **No**

If yes, what is the name of the surgery? _____

Have you ever had epidural steroid injections? ☐ **Yes** ☐ **No**

If yes, did it help? ☐ **Yes** ☐ **No**

Are you currently taking any blood thinners? ☐ **Yes** ☐ **No**

MEDICAL HISTORY

Do you have any of the following medical conditions? Please check all that apply.

☐ High blood pressure ☐ Kidney disease ☐ Suppressed immune system

☐ Liver disease ☐ Cancer ☐ Diabetes

☐ Thyroid disease ☐ Stomach ulcers ☐ Heart disease

☐ Bleeding problems ☐ Seizure disorder ☐ Chest pain

☐ Rheumatoid Arthritis ☐ Asthma ☐ COPD

☐ Any contagious disease ☐ Other

Please explain any of the above YES, or any other medical problems you may have:

_____

Please list all drugs ***allergies***: _____

Please list all previous ***surgeries***:

Surgery	Date (MM/YY)
_____	_____
_____	_____
_____	_____
_____	_____

Please list all pain medications you are currently taking:

_____

_____

_____

_____

Please list all other medications you are currently taking:

_____

_____

_____

_____

Please list all medical illnesses or conditions in your family, *if any*:

_____

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

If yes, how long have you smoked? _____ How much do you smoke per week? _____

Do you drink alcohol? ☐ None ☐ Rarely ☐ Socially ☐ Other: _____ drinks/week

Do you have a social history of drug or alcohol abuse? ☐ Yes ☐ No

With whom do you live? ☐ Alone ☐ Spouse/children ☐ Roommates

☐ Other: _____

Occupation _____ Name of Employer _____

VERIFICATION OF INFORMATION

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE ***DATE***

_____

RELATIONSHIP TO PATIENT