ILLINOIS PAIN AND SPINE INSTITUTE

600 Hart Rd. Suite 320 ● Barrington, IL 60010 ● (O) : (847) 852 2000 ● (F) : (847) 381 0882

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Date of birth : _____ / _____ / _____ Sex ☐ M ☐ F

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

E-Mail: _____

How did you hear about the office : _____

_____

_____

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

_____

RESPONSIBLE PARTY (If patient is un der 18 years of age)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: _____

Phone: (_____)_____ Occupation: _____

INSURANCE INFORMATION

My insurance is : ☐ PPO ☐ HMO ☐ Federal funded (i.e. Medicare/Medicaid) ☐ I do not have health insurance

Insurance Company: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber's Date of birth : _____ / _____ / _____

Relationship to Subscriber : _____ Subscriber's Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Is your visit a result of a motor vehicle / work accident? ☐ Yes ☐ No **(if yes, please inform the front desk)**

PAST HEALTH HISTORY

Surgeries: ☐ I have never had any surgeries

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Previous Injury or trauma: _____

Have you ever broken any bones? If so, which? : _____

Allergies? : _____

I attest that the information I have given here on this and the following forms is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Account# :_____

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Family History (check all that apply) ☐ None apply

Condition	Family Member (s)	Condition	Family Member(s)
☐ Heart disease	_____	☐ Scoliosis	_____
☐ Stroke	_____	☐ Spine problems	_____
☐ High Blood Pressure	_____	☐ Kidney failure	_____
☐ Diabetes	_____	☐ Mental illness	_____
☐ Osteoporosis	_____	☐ Bleeding disorders	_____
☐ Rheumatoid Arthritis	_____	☐ Anemia	_____
☐ Osteo Arthritis	_____	☐ Alcohol dependence	_____
☐ Lupus	_____	☐ Cancer	_____
☐ Sickle Cell	_____	☐ Other: _____	_____

Social History

Marital Status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have children? ☐ Yes ☐ No If yes, what are their ages: _____

Are you, or could you be, pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? _____

Risk Factors

Do you smoke or use tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate quantity: _____ drink per ☐ Day ☐ Week ☐ Month

Do you Exercise? ☐ Yes ☐ No What type?: _____ How many days per week? _____

Medications / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

Patient Name (please print): _____ Date: _____ Account# :_____

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REVIEW OF SYSTEMS

Have you ever had any of the following **pulmonary (lung related)** issues? ☐ None apply

☐ Asthma / Difficulty Breathing ☐ COPD ☐ Emphysema ☐ Other : _____

Have you ever had any of the following **cardiovascular (heart related)** issues or procedures? ☐ None apply

☐ Heart Surgeries ☐ Congestive Heart Failure ☐ Mumurs / Vascular Disease ☐ Pacemaker
☐ Heart Attack / MI ☐ Heart Disease / Problems ☐ Angina / Chest Pain ☐ Irregular Heartbeat
☐ Hypertension ☐ Other : _____

Have you ever had any of the following **neurological (nerve related)** issues or procedures? ☐ None apply

☐ Headaches ☐ Tremors ☐ One-sided weakness in face or body ☐ Loss of sense of smell
☐ Memory Loss ☐ Vertigo ☐ One-sided decrease of feeling face or body ☐ Visual changes / loss of vision
☐ Stroke / TIA ☐ Other : _____

Have you ever had any of the following **endocrine (glandular/hormonal related)** issues or procedures? ☐ None apply

☐ Thyroid Disease ☐ Hormone Replacement Therapy ☐ Diabetes
☐ Injectable Steroid Replacements ☐ Other : _____

Have you ever had any of the following **renal (kidney related)** issues or procedures? ☐ None apply

☐ Renal Calculi / Kidney Stones ☐ Hematuria (blood in urine) ☐ Bladder Infections
☐ Incontinence (can't control) ☐ Difficulty Urinating ☐ Kidney Disease
☐ Dialysis ☐ Other : _____

Have you ever had any of the following **gastroenterological (stomach related)** issues or procedures? ☐ None apply

☐ Nausea ☐ Difficulty Swallowing ☐ Ulcerative Disease
☐ Frequent Abdominal Pain ☐ Hiatal Hernia ☐ Constipation
☐ Pancreatic Disease ☐ Irritable Bowel / Colitis ☐ Hepatitis / Liver Disease
☐ Bloody / Black Tarry Stools ☐ Vomiting Blood ☐ Bowel Incontinence
☐ Gastroesophageal reflux / Heartburn ☐ Other : _____

Have you ever had any of the following **hematological (blood related)** issues or procedures? ☐ None apply

☐ Abnormal bleeding/bruising ☐ History of Blood Clots ☐ HIV Positive ☐ Hemophilia
☐ Anticoagulant Therapy ☐ Sickle-cell Anemia ☐ Enlarged Lymph Nodes ☐ Anemia
☐ Regular anti-inflammatory use ☐ Deep Vein Thrombosis
☐ Regular Aspirin Use ☐ Other : _____

Have you ever had any of the following **dermatological (skin related)** issues or procedures? ☐ None apply

☐ Significant Burns ☐ Significant Rash ☐ Skin Grafts
☐ Psoriatic Disorders ☐ Other : _____

Have you ever had any of the following **musculoskeletal (bone/muscle related)** issues or procedures? ☐ None apply

☐ Rheumatoid Arthritis ☐ Gout ☐ Osteoarthritis
☐ Broken Bones ☐ Spinal Fracture ☐ Spinal Surgery
☐ Joint Surgery ☐ Arthritis (unknown type) ☐ Scoliosis
☐ Metal Implants ☐ Other : _____

Is there anything else in your medical history that you feel is important to your care here : _____

_____

Patient Name (please print): _____ Date: _____ Account# :_____

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NEW PATIENT HISTORY (if you need additional sheets, please ask the front desk)

- **Primary Complaint :** _____
- On a scale from 0 - 10 (10 being the worst), please check the number that best describes the level of the symptoms most of the time :

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

- What percentage of the time you are awake do you experience the above symptoms at the above intensity?

10	20	30	40	50	60	70	80	90	100
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

- How did the symptoms start? ☐ Gradually ☐ Suddenly When did the symptoms start? _____
- How did the symptoms begin? _____
-
- What makes the symptoms worse? (check all that apply)
  - ☐ Nothing ☐ Any movement ☐ looking up ☐ looking down
  - ☐ tilting head to left ☐ tilting head to right ☐ looking left ☐ looking right
  - ☐ bending forward at waist ☐ bending back at waist ☐ leaning to left ☐ leaning to right
  - ☐ twisting to left ☐ twisting to right ☐ driving ☐ standing
  - ☐ walking ☐ running ☐ lifting ☐ sitting
  - ☐ standing from sitting ☐ chewing ☐ lying down ☐ reading
  - ☐ working ☐ exercise ☐ lying on right side ☐ lying on left side
  - ☐ Other : _____
- What makes the symptoms better? (check all that apply)
  - ☐ Nothing ☐ ice ☐ heat ☐ rest
  - ☐ movement ☐ stretching ☐ exercise ☐ walking
  - ☐ prescription meds ☐ OTC anti-inflammatory ☐ adjustments ☐ massage
  - ☐ Other : _____
- What is the quality of the symptom? (check all that apply)
  - ☐ Aching ☐ Burning ☐ Cramping ☐ Deep
  - ☐ Dizziness ☐ Dull ☐ Pinching ☐ Pins / Needles
  - ☐ Sharp ☐ Sharp with movement ☐ Sore ☐ Stabbing
  - ☐ Stiffness ☐ Throbbing ☐ Tingling
  - ☐ Other : _____
- Does the symptom travel/radiate to another part of your body? ☐ Yes ☐ No
  If yes, where does it travel to? _____
- Is the symptom worse at certain times of the day or night (check all that apply)
  ☐ No difference ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
- Have you received treatment for this condition and episode prior to today's visit ? (check all that apply)
  - ☐ No treatment ☐ Anti Inflammatory Meds ☐ Pain Medication ☐ Muscle Relaxers
  - ☐ Injections ☐ Surgery ☐ Heat / Ice ☐ Massage
  - ☐ Physical Therapy ☐ Chiropractic Care ☐ Other: _____
- Since the start of the most recent episode how is your symptom progressing ? ☐ Worse ☐ Same ☐ Better
- What are some things your symptoms are preventing you from doing specifically either partially or completely:
  _____

Patient Name (please print): _____ Date: _____ Account# : _____