_____, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

THE SPINE HOSPITAL
AT THE NEUROLOGICAL INSTITUTE OF NEW YORK

UNIT # _____

PATIENT INFORMATION

Date: _____/____/_____
Patient Name:

_____
(**Last** Name)

_____ _____
(**First** Name) (Middle Initial)

Date of Birth: _____/____/_____ Sex: □ M □ F

Address: _____
City: _____
State: _____ Zip: _____
Home #: (_____) _____-_____
Cell #: (_____) _____-_____
Email: _____

Father's First Name: _____
Mother's First Name: _____
Employer's Name: _____
Occupation: _____
Work #: (_____) _____-_____
Fax #: (_____) _____-_____

Spouse Name: _____
(**Last** Name)

_____
(**First** Name)
Date of Birth: _____/____/_____

Cell #: (_____) _____-_____
Email: _____

<u>If different than patient:</u>

Guarantor's Name: _____
(**Last** Name)

_____
(**First** Name)
Date of Birth: _____/____/_____ Sex: □ M □ F

Cell #: (_____) _____-_____

INSURANCE

Primary Insurance: _____
Policy #: _____
Group #: _____
Phone #: (_____) _____-_____

Secondary Insurance: _____
Policy #: _____
Group #: _____
Phone #: (_____) _____-_____

Check if apply and answer the following questions:
□ Workers Compensation
□ Auto Accident/NoFault
Date of Accident: _____/____/_____
Carrier Name: _____
Representative Name: _____
State of Accident: _____
Policy #: _____
Address: _____
Phone #: (_____) _____-_____

REFERRING PHYSICIAN

Referring Physician Name:

_____
Address: _____
Phone #: (_____) _____-_____

Primary Care Physician Name:

_____
Address: _____
Phone #: (_____) _____-_____

Pharmacy Name: _____
Address: _____
Phone #: (_____) _____-_____

_____, M.D.
Neurosurgical Associates, P.C.
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New York, NY 10032

UNIT # _____

PATIENT FINANCIAL OBLIGATION AGREEMENT

I understand that all applicable copayments and deductibles are due at the time of services. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Neurosurgical Associates, P.C. for services rendered. I authorize representatives of Neurosurgical Associates/Columbia University Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. If my current policy prohibits direct payment to the doctor, I will forward the check and explanation of benefits to Neurological Associates.

Patient Signature: _____
Date: _____/____/_____

Guarantor Signature: _____
Date: _____/____/_____

I am aware that _____, M.D. does not participate with my Commercial Insurance and is an Out-of-Network Provider.

Patient Signature: _____
Date: _____/____/_____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name: (Print) _____

Patient Signature: _____ Date: _____/_____/_____

If completed by a patient's representative, please print and sign below:

Representative: (Print) _____ Relationship: _____

Representative Signature: _____ Date: _____/_____/_____

MYCOLUMBIADOCTORS PATIENT PORTAL SIGN UP

Access your personal records securely, 24/7, on a computer, smartphone, or iPad.

□ YES, Send me an invitation to join myColumbiaDoctors. Email: _____
□ **NO, do not** send me an invitation to join myColumbiaDoctors.

Look for an email invite from **noreply@followmyhealth.org** and click the registration link.

Patient's Preferred Language _____ □ I decline to respond.

Patient Signature: _____ Date: _____/_____/_____

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

DEMOGRAPHIC INFORMATION

Full name _____ DOB _____ Age _____

Address_____

Email_____

Phone numbers (H)_____ (W)_____ (C)_____

Emergency contact_____ Phone _____

CARE INFORMATION

Primary care physician:_____

Address_____

Phone_____ Fax_____

Referring physician:_____ Specialty _____

Address_____

Phone_____ Fax_____

REASON FOR VISIT

Please describe the major problem that brings you in today to see a spine surgeon:

_____

_____

Is this visit related to worker's compensation? ☐ No ☐ Yes

Is this visit related to any legal actions? ☐ No ☐ Yes

If this problem is the result of an accident, when did the accident occur? _____

Was it a motor vehicle accident? ☐ No ☐ Yes

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

MEDICAL HISTORY

Height _____ feet _____ inches Weight _____ pounds

Please list all **OPERATIONS** you have had. Date:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all **ACTIVE MEDICAL PROBLEMS**. Duration:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **ALLERGIC** to any medicines, latex, x-ray dye, or iodine?

If yes, please explain: _____

Have you had any **PROBLEMS WITH ANESTHESIA**?

If yes, please explain: _____

Are you taking any **BLOOD THINNING MEDICATIONS**? ☐ Yes – indicate below ☐ No

☐Aspirin or aspirin-containing medication
☐Anti-inflammatory medication (for example, Advil, Motrin, Celebrex)
☐Plavix
☐Coumadin
☐Fish oil
☐Other:_____

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

REVIEW OF SYSTEMS

CARDIOVASCULAR

Chest pain/pressure	☐Y	☐N
Fainting	☐Y	☐N
Heart attack	☐Y	☐N
Heart defect	☐Y	☐N
Heart murmur	☐Y	☐N
High blood pressure	☐Y	☐N
Low blood pressure	☐Y	☐N
Leg swelling	☐Y	☐N

CONSTITUTIONAL

Altered taste/smell	☐Y	☐N
Change in appetite	☐Y	☐N
Excessive sleepiness	☐Y	☐N
Fatigue	☐Y	☐N
Fever	☐Y	☐N
Depression	☐Y	☐N
Anxiety	☐Y	☐N
Recent sore throat	☐Y	☐N
Sleep apnea	☐Y	☐N
Weight loss or gain	☐Y	☐N

EAR, NOSE, & THROAT

Hearing loss	☐Y	☐N
Mouth sores	☐Y	☐N
Ringing in ears	☐Y	☐N
Sinus disease	☐Y	☐N
Trouble swallowing	☐Y	☐N

EYES

Blurred vision	☐Y	☐N
Cataracts	☐Y	☐N
Double vision	☐Y	☐N
Glaucoma	☐Y	☐N
Macular degeneration	☐Y	☐N
Peripheral vision issue	☐Y	☐N
Visual impairment	☐Y	☐N

GASTROINTESTINAL

Black stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Gall bladder problems	☐Y	☐N
Ulcer	☐Y	☐N
Vomiting	☐Y	☐N

SKIN

Birth marks	☐Y	☐N
Psoriasis	☐Y	☐N
Skin rashes	☐Y	☐N
Melanoma	☐Y	☐N

RESPIRATORY

Asthma	☐Y	☐N
Bronchitis	☐Y	☐N
Chronic cough	☐Y	☐N
COPD	☐Y	☐N
Emphysema	☐Y	☐N
Pneumonia	☐Y	☐N
Shortness of breath	☐Y	☐N
Trouble breathing	☐Y	☐N
Tuberculosis	☐Y	☐N
Wheezing	☐Y	☐N

MUSCULOSKELETAL

Connective tissue disorder	☐Y	☐N
Low back pain	☐Y	☐N
Neck pain	☐Y	☐N
Joint pain	☐Y	☐N
Joint replacement	☐Y	☐N
Joint swelling	☐Y	☐N

GENITOURINARY

Blood in urine	☐Y	☐N
Change in habits	☐Y	☐N
Urinary infections	☐Y	☐N
Kidney disease	☐Y	☐N
Kidney stones	☐Y	☐N
Loss of control	☐Y	☐N
Painful urination	☐Y	☐N
Urinary urgency	☐Y	☐N
Vaginal bleeding	☐Y	☐N

HEMOLYMPHATIC/ ENDOCRINE

Anemia	☐Y	☐N
Blood disorder	☐Y	☐N
Circulatory problems	☐Y	☐N
Diabetes	☐Y	☐N
Dry eyes/mouth	☐Y	☐N
Endocrine disorder	☐Y	☐N
Low blood sugar	☐Y	☐N
Lymph node swelling	☐Y	☐N
Hepatitis	☐Y	☐N
HIV/AIDS	☐Y	☐N
Pituitary disorder	☐Y	☐N
Sickle cell disease	☐Y	☐N
Thyroid disease	☐Y	☐N

NEUROLOGICAL

Balance difficulty	☐Y	☐N
Choking	☐Y	☐N
Clumsiness	☐Y	☐N
Concussion	☐Y	☐N
Confusion	☐Y	☐N
Concentration difficulty	☐Y	☐N
Dizziness	☐Y	☐N
Drooling	☐Y	☐N
Falls	☐Y	☐N
Hallucinations	☐Y	☐N
Headache	☐Y	☐N
Loss of consciousness	☐Y	☐N
Memory problems	☐Y	☐N
Muscle twitching	☐Y	☐N
Nausea	☐Y	☐N
Numbness	☐Y	☐N
Personality change	☐Y	☐N
Seizure	☐Y	☐N
Shooting pains	☐Y	☐N
Smelling difficulty	☐Y	☐N
Stroke	☐Y	☐N
Tasting difficulty	☐Y	☐N
Tingling sensation	☐Y	☐N
Vertigo	☐Y	☐N
Walking difficulty	☐Y	☐N

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

SOCIAL HISTORY

Are you married? ☐ No ☐ Yes ☐ Separated/divorced ☐ Widow(er)

What is your **SMOKING** HISTORY?
- ☐ Currently smoke **every day** How much daily? _____
- ☐ Currently smoke **some days** How much weekly? _____
- ☐ Formerly smoked
- ☐ Never smoked

Do you drink alcohol? ☐ No ☐ Yes Drinks per day: _____
Use any recreational drugs? ☐ No ☐ Yes Please specify: _____
Prior alcohol or drug abuse? ☐ No ☐ Yes Please explain: _____

Do you participate in activities inside the home (i.e. vacuuming, cooking, general housework)?
☐ No ☐ Yes
If yes, describe your level of activity: ☐ Sendentary or light ☐ Moderate ☐ Strenuous

Do you participate in activities outside the home (i.e. gardening, golf, walking, cycling, volunteering)?
☐ No ☐ Yes
If yes, describe your level of activity: ☐ Sendentary or light ☐ Moderate ☐ Strenuous

What is the highest level of **EDUCATION** you have achieved? (Check one)
- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ Two-year college degree
- ☐ Four-year college degree
- ☐ Post-college

Are you currently **EMPLOYED** (paid employee or self-employed)? (Check all that apply)
- ☐ Employed and currently working
  - ☐ Full time
  - ☐ Part time
- ☐ Employed but not working
  - ☐ On short-term disability
- ☐ On leave
- ☐ Unemployed
  - ☐ On disability
  - ☐ Retired
  - ☐ Homemaker
  - ☐ None of the above
- ☐ Attending school

If disabled or unemployed, is this due to your **spinal condition**? ☐ No ☐ Yes

Was your spinal condition work related? ☐ Yes ☐ No ☐ Unknown

Which description best characterizes your occupation?
- ☐ Sendentary: requires the ability to sit up to 6 hours in an 8-hour work day, lift light objects such as files and paperwork frequently during the day, and objects weighing up to 10 pounds occasionally during the day
- ☐ Light: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 10 pounds frequently and up to 20 pounds occasionally
- ☐ Medium: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 25 pounds frequently and 50 pounds occasionally
- ☐ Heavy: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 50 pounds frequently and lift more than 50 pounds occasionally

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

FAMILY HISTORY

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancer, etc.) please list below.

Relationship_____ Age _____ Condition _____
Relationship_____ Age _____ Condition _____
Relationship_____ Age _____ Condition _____
Relationship_____ Age _____ Condition _____
Relationship_____ Age _____ Condition _____
Relationship_____ Age _____ Condition _____

Do you have children? ☐ No ☐ Yes If yes, age(s) and condition

_____
_____

SIGNATURES

This form is confidential and is part of your medical record.

Completed by: _____ _____ _____
Printed Signature Date

Reviewed by: _____, M.D. _____ _____
Printed Signature Date

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form
Lumbar spine

Patient Identification Information

Please place an "X" anywhere on the line below to indicate the proportion of your pain that is located in your back and legs:

All back pain — Equal pain in back and legs — All leg pain

Please place an "X" anywhere on the line below the side of your leg pain, if present.

All LEFT leg pain — Pain EQUAL in left and right legs — All RIGHT leg pain

1. There is: ☐ No weakness of the legs ☐Weakness of the (check the following):
   Right: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big toe
   Left: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big toe

2. There is: ☐ No numbness of the legs ☐Numbness of the (check the following):
   Right: ☐ Thigh ☐ Calf ☐ Foot
   Left: ☐ Thigh ☐ Calf ☐ Foot

3. The worst position for the pain is: ☐ sitting ☐ standing ☐ walking.

4. How many minutes can you stand in one place without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

5. How many minutes can you walk without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

6. Lying down: ☐ Eases the pain ☐ Does not ease the pain ☐ Sometimes eases the pain

7. Bending forward: ☐ Increases the pain ☐ Decreases the pain ☐ Doesn't affect the pain

8. Coughing or sneezing (☐ Increases ☐ Sometimes increases ☐ Does not increase) the pain.

9. There is: ☐ No loss of bowel or bladder control ☐ Loss of bowel or bladder control since _____

10. I have: ☐ Not missed any work because of this problem ☐ Missed (how much?) _____work.

11. Treatments for my back have included:

- ☐ No medicines, therapy, manipulations, injections, or braces.
- ☐ Physical therapy, exercise
- ☐ Massage & ultrasound
- ☐ Traction
- ☐ Manipulation
- ☐ TENS unit
- ☐ Braces
- ☐ Anti-inflammatory medications
- ☐ Narcotic medication
- ☐ Epidural steroid injections ____times which relieved the pain for (how long?) _____
- ☐ Trigger point injections ____times which relieved the pain for (how long?) _____
- ☐ Other: _____

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form
Lumbar spine

Patient Identification Information

OSWESTRY DISABILITY INDEX 2.1A

Please read instructions: Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity
☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (Washing, Dressing, etc.)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it is very painful
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but manage most of my personal care
☐ I need help every day in most aspects of self care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking
☐ Pain does not prevent me walking any distance.
☐ Pain prevents me walking more than 1 mile.
☐ Pain prevents me walking more than ¼ of a mile.
☐ Pain prevents me walking more than 100 yards.
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
☐ I can sit in any chair as long as I like.
☐ I can sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than half an hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 – Standing
☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than half an hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 – Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain, I have less than 6 hours of sleep.
☐ Because of pain, I have less than 4 hours of sleep.
☐ Because of pain, I have less than 2 hours of sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)
☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal but causes some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex life at all.

Section 9 – Social life
☐ My social life is normal and causes me no extra pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 10 – Travel
☐ I can travel anywhere without pain.
☐ I can travel anywhere but it gives extra pain.
☐ Pain is bad but I manage journeys over two hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me traveling except to receive treatment.

EQ-5D

By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about ❑
I have some problems in walking about ❑
I am confined to bed ❑

Self-Care

I have no problems with self-care ❑
I have some problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑
I have some problems with performing my usual activities ❑
I am unable to perform my usual activities ❑

Pain/Discomfort

I have no pain or discomfort ❑
I have moderate pain or discomfort ❑
I have extreme pain or discomfort ❑

Anxiety/Depression

I am not anxious or depressed ❑
I am moderately anxious or depressed ❑
I am extremely anxious or depressed ❑

COLUMBIA UNIVERSITY MEDICAL CENTER

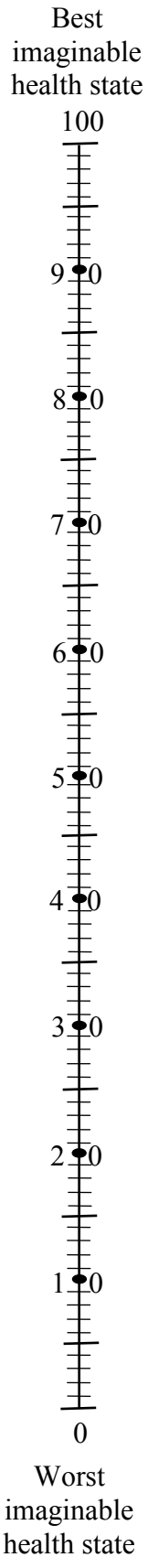
Spine Center
New Patient Intake Form
Lumbar spine

Patient Identification Information

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form
Lumbar spine

Patient Identification Information

VISUAL ANALOGUE SCALE

How severe is your BACK pain today? Place a vertical mark on the line below to indicate how bad you feel your BACK pain is today.

No pain Very severe pain

How severe is your LEG pain today? Place a vertical mark on the line below to indicate how bad you feel your LEG pain is today.

No pain Very severe pain

SIGNATURES

Patient's signature Date

Patient Identification Information

Physician's signature Date