ColumbiaDoctors

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Gender: _____ Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Referring Provider: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: ☐ Decline Response

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

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

☐ Received ☐ N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

***Please refer to our website: columbiadoctors.org, for a list of insurances accepted by your provider.**

Reason for today's visit:

General Medical Questionnaire
Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y □ N	Heart Disease/Disorder	□ Y □ N
Arthritis	□ Y □ N	Lung Disorder	□ Y □ N
Bleeding/Clotting Disorder	□ Y □ N	Liver Disease	□ Y □ N
Blood Pressure Disorder	□ Y □ N	Neurological Disorder/Chronic Headaches	□ Y □ N
Blood Transfusion	□ Y □ N	Psychiatric Disorder/Illness	□ Y □ N
Bowel/Stomach Problems	□ Y □ N	Pulmonary Embolism/DVT	□ Y □ N
Cancer	□ Y □ N	Stroke	□ Y □ N
Cholesterol Disorder	□ Y □ N	Seizure or Epilepsy	□ Y □ N
Diabetes	□ Y □ N	Thyroid Disorder	□ Y □ N
Eye Disorder (i.e. Glaucoma, cataract)	□ Y □ N	Urinary/Kidney Disorder	□ Y □ N
Women Only: Gynecological Issues	□ Y □ N		

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked _____ Packs/day _____

Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: _____

Women Only: Any past pregnancies? □ Y □ N How many? ___ How many deliveries? ___

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Review of Systems
Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

□Y□N Fever	□Y□N Fatigue	□Y□N Weight Gain (___ Lbs)	□Y□N Sleep Disturbances
□Y□N Chills	□Y□N Feeling Poorly	□Y□N Weight Loss (___ Lbs)	□ Other:
	□Y□N Sweats	□Y□N Unexp. Weight Change	

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem	□Y□N Red Eyes	□Y□N Congestion	□Y□N Hoarseness
□Y□N Decreased Hearing	□Y□N Eye Pain	□Y□N Snoring	□Y□N Ringing in Ears
□Y□N Double Vision	□Y□N Runny Nose	□Y□N Dry Mouth	□Y□N Vertigo
□Y□N Light Sensitivity	□Y□N Neck Stiffness	□Y□N Flu-Like Symptoms	□Y□N Earache
□Y□N Itchy Eyes	□Y□N Nosebleed	□Y□N Sore Throat	□Y□N Other:

Cardiovascular

□Y□N Chest Pain	□Y□N Cold Extremities	□Y□N Irregular Heart Rhythm
□Y□N Palpitations	□Y□N Cold Hands or Feet	□Y□N Other:
□Y□N Leg Swelling	□Y□N Leg Pain w/ Walking	

Respiratory

□Y□N Shortness of Breath	□Y□N Wheezing	□Y□N Coughing Up Blood	□
□Y□N Cough	□Y□N Shortness of Breath	□Y□N Coughing Up Sputum	
□Y□N Rapid Breathing	□Y□N Chest Congestion	□ Other:	

Gastrointestinal

□Y□N Abdominal Pain	□Y□N Diarrhea	□Y□N Change in Bowels	□Y□N Painful Swallowing
□Y□N Blood in Stool	□Y□N Black/Tarry Stools	□Y□N Vomiting Blood	□ Other:
□Y□N Vomiting	□Y□N Decreased Appetite	□Y□N Bowel Incontinence	
□Y□N Nausea	□Y□N Yellow Skin	□Y□N Rectal Pain	

□Y□N Constipation	□Y□N Trouble Swallowing	□Y□N Heartburn	

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Oizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression	□Y□N Anxiety	□Other:

Hematologic/Lymphatic

□Y□N Easy Bruising	□Y□N Easy Bleeding	□Y□N Swollen Lymph Nodes	□ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other:

OFFICE USE ONLY: Provider Signature: _____ Date: _____

Patient Identification Information

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	❑

NECK DISABILITY INDEX

Please read: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and 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 causes extra pain
- ☐ 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, I wash with difficult 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 very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want to with moderate pain in my neck
- ☐ I can't read as much as I want because of pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5 – Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Section 7 – Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

Section 8 – Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I cannot drive my car as long as I want because of Pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck

Section 9 – Sleeping

- ☐ I have no problem sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-6 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation

- ☐ I am amble to engage in all my recreational activities with no neck pain at all
- ☐ I am able to engage in all my recreational activities with some pain in my neck
- ☐ I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
- ☐ I am able to engage in few of my usual recreational activities because of pain in my neck
- ☐ I can hardly do any recreational activities because of pain in my neck
- ☐ I cannot do any recreational activities at all

Weill Cornell Medicine | NewYork-Presbyterian | COLUMBIA

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. Organizations that will follow this notice include Weill Cornell Medicine, NewYork-Presbyterian sites, Columbia University and their entities.

Date: _____

I acknowledge that I was provided with a copy of the Weill Cornell Medicine, NewYork-Presbyterian and Columbia University Notice of Privacy Practices.

Patient Name (Print): _____

Patient (Signature): _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print): _____

Personal Representative/Guardian (Signature): _____

Relationship to the patient: _____

☐ Please check this box if you wish to have your name, location, and health condition removed from the hospital directory that is used to disclose your admission status to external party queries. (For NYP Use Only)