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
Arthritis .... □ Y □ N
Bleeding/Clotting Disorder .... □ Y □ N
Blood Pressure Disorder .... □ Y □ N
Blood Transfusion .... □ Y □ N
Bowel/Stomach Problems .... □ Y □ N
Cancer .... □ Y □ N
Cholesterol Disorder .... □ Y □ N
Diabetes .... □ Y □ N
Eye Disorder (i.e. Glaucoma, cataract) .... □ Y □ N
Women Only: Gynecological Issues .... □ Y □ N

Heart Disease/Disorder .... □ Y □ N
Lung Disorder .... □ Y □ N
Liver Disease .... □ Y □ N
Neurological Disorder/Chronic Headaches .... □ Y □ N
Psychiatric Disorder/Illness .... □ Y □ N
Pulmonary Embolism/DVT .... □ Y □ N
Stroke .... □ Y □ N
Seizure or Epilepsy .... □ Y □ N
Thyroid Disorder .... □ Y □ N
Urinary/Kidney Disorder .... □ 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 Chills
☐Y☐N Fatigue
☐Y☐N Feeling Poorly
☐Y☐N Sweats
☐Y☐N Weight Gain (___ Lbs)
☐Y☐N Weight Loss (___ Lbs)
☐Y☐N Unexp. Weight Change
☐Y☐N Sleep Disturbances
☐ Other:

Head, Eyes, Ears, Nose, and Throat

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

☐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 Dizziness	☐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: __________

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 ovar 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.

COLUMBIA UNIVERSITY
MEDICAL CENTER

Spine Center
New Patient Intake Form
Lumbar spine

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 ☐

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)