CBSI
COLORADO BRAIN & SPINE INSTITUTE
P303-783-8844 F303-783-2002
Leaders in Neurosurgical Care™

Room # _____

NEW PATIENT QUESTIONNAIRE

Thank you for taking the time to complete this form.
This will help us offer you the most comprehensive medical care.

PATIENT NAME: _____

Your current height: _____

Your current weight: _____ lbs

List prior/current treatments FOR THE PROBLEM YOU ARE BEING SEEN FOR TODAY:

Treatment	Length of time of Treatment	Date of Last Treatment	Spinal Level of Injection	Improved with this treatment? Yes / No / Worse
NSAIDS (non-steroidal anti-inflammatories)			N/A	
Narcotics			N/A	
Muscle Relaxants			N/A	
Steroid Medications			N/A	
Physical Therapy			N/A	
Chiropractic Therapy			N/A	
Acupuncture			N/A	
Epidural Steroid Injections (how many?)				
Selective Nerve Root Injections (how many?)				
Facet Injections (how many?)				
Radiofrequency Ablations (how many?)				
Surgeries for **THIS** problem, *list procedure and date:*				

Are you having other problems that your MD/PA needs to know about? (continued on next page)

If yes, please CIRCLE OR LIST your problems. Needed for accurate chart documentation for your insurance:

☐ **No** ☐ **Yes** **General Constitutional** (Fatigue, Fever, Unintentional weight loss, Unintentional weight gain)
If other general problem, list: _____

☐ **No** ☐ **Yes** **Eyes:** (Blurring, Double vision, Vision loss, Eye pain, Photophobia)
If other eye problem, list: _____

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PATIENT NAME: ____

(Continued from previous page)

Are you having other problems that your MD/PA needs to know about?

*****If yes, please <u>CIRCLE OR LIST</u> your problems. Needed for accurate chart documentation for your insurance:***

☐ **No** ☐ **Yes** **<u>Ear, Nose, Mouth, Throat</u>** (Hearing loss, ringing in ears, Allergies, Sinus trouble, Nosebleeds, or Sore throat)
If other ENT problem, list: ____

☐ **No** ☐ **Yes** **<u>Heart and Blood Vessels</u>** (Chest pain, Irregular heartbeat, or Heart murmur)
If other heart problem, list: ____

☐ **No** ☐ **Yes** **<u>Lungs and Respiratory System</u>** (Shortness of breath, Coughing up blood, Sputum, or Wheezing)
If other lung problem, list: ____

☐ **No** ☐ **Yes** **<u>Stomach and Digestive System</u>** (Difficulty swallowing, Heartburn, Nausea, Vomiting, Diarrhea, Abdominal pain, Constipation, or Blood in bowel movement)
If other GI problem, list: ____

☐ **No** ☐ **Yes** **<u>Genito-Urinary System</u>** (Incontinence, Painful urination, Blood in urine, Urinary frequency, Menstrual cycle stopped, Decreased libido, Sexually transmitted disease)
If other GU problem, list: ____

☐ **No** ☐ **Yes** **<u>Bones, Joints, or Muscles</u>** (Cramping, Weakness, Fatigue of muscles, Change in size of muscle, or Joint pain or inflammation)
If other muscle problem, list: ____

☐ **No** ☐ **Yes** **<u>Brain and Nervous System</u>** (Fainting, Blackout spells, Seizures, Paralysis of limbs, Speech difficulty, Memory loss, Pain or numbness of spine, arms, or legs)
If other problem, list: ____

☐ **No** ☐ **Yes** **<u>Mental and Emotional Health</u>** (Nervousness, Tension, Mood swings, or Depression)
If other problem, list: ____

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FOR INTERNAL STAFF USE ONLY:

Vitals: RR ______________ **HR (pulse)** ______________ **BP** ______________________ **BMI** _____________

Final check before routing: ☐ Front Desk - if no PCP, put alert note no PCP ☐ PA- enter charges ☐ PA- Enter PQRS

☐ PA- edit/spell check ☐ MD MA- enter all MDs that need to be cc, have MA enter them into contacts
~~~~~~

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INSURANCE INFORMATION

Please complete this form completely. Please print.

Patient Name as it appears on card: _____

***Primary Insurance*: ☐Health ☐Work Comp ☐Auto (for Work Comp or Auto, please see below regarding accident)**

Name of Insurance Company_____

ID # _____ Group # _____ Phone (_____) _____-_____

Insurance address: _____ City_____ State _____Zip _____

Name of Insured Member: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child/Other

Date of Birth of Insured Member: _____/_____/_____ Social Security # of insured member_____

(If your insurance requires a referral authorization from your PCP, please provide a copy to our office.)

***Secondary or Supplemental Insurance*:** **Check here if no secondary or other insurance: ☐**

Name of Insurance Company_____ (*Please see below if Medicare is secondary)

ID # _____ Group # _____ Phone (_____) _____-_____

Insurance address: _____ City_____ State _____Zip _____

Name of Insured Member: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child/Other

Date of Birth of Insured Member: _____/_____/_____ Social Security # of insured member_____

**If Medicare is your secondary insurance please indicate the reason below (required for us to file claim):*

☐ Working Aged Beneficiary or Spouse with Employer Group Plan
☐ Disabled Beneficiary under age 65 with Group Health Plan
☐ No-fault insurance (including Auto) is Primary
☐ Veteran's Administration
☐ Worker's Comp is Primary
☐ Other Liability Insurance is Primary

***Accident Related Visits:* (Complete this section only if to be billed to: ☐Work Comp or ☐Auto)**

(If billed to Auto Medical, we can **only** bill on your policy and **only** if you have proof of Medical Payments on your policy –
We cannot bill a third party auto insurance or other liability carrier. If no Medical Payments on your policy we must bill your health insurance.)

Exact date of injury: _____/_____/_____ (mm/dd/yyyy) WC/Auto Claim #: _____

For Work Comp Claims ONLY:

Employer at time of Injury: _____ Occupation _____
Work Address: _____ City _____ State _____ Zip _____
Current employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Retired

Authorization: I hereby authorize release of information necessary to file a claim on my behalf with CMS (Medicare) and its agents and all other insurance carriers. I authorize Colorado Brain & Spine Institute LLC PC (CBSI) to appeal on my behalf, any insurance carrier's payment or decision.
Assignment: I hereby assign medical benefits otherwise payable to me to CBSI. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand that I am responsible for all copays, deductibles, co-insurance and balances.
Release: I hereby consent to the release all information provided to, or generated by CBSI, to my PCP, referring physician, psychologist, attorney, therapist, agency, or any other party with a bona-fide or pertinent interest via verbal, written, or fax/email communication. A copy or scanned image of my signature shall be as valid as the original.

Patient signature _____ _____ Date: ____/_____/_____

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Patient Name: _____ DOB: _____/_____/_____ (mm/dd/yyyy)

Present Complaint _____

_____

_____ Duration of complaints/problems: _____

PAST MEDICAL HISTORY: ☐ ***NEGATIVE/UNREMARKABLE*** OR √ BOX THAT APPLIES TO YOU

Medical	**Medical**	**Neurologic**	**Pertinent to surgery**
☐ Anemia	☐ GERD/Reflux	☐ Aneurysm	☐ Anticoagulation Therapy
☐Anxiety	☐ Glaucoma	☐ CVA/Stroke	☐ Bleeding Disorder
☐ Asthma	☐ Gout	☐ Brain Tumor	☐ Chronic Pain
☐ Atrial Fibrillation	☐ Heart Disease	☐ Hydrocephalus	☐ Clotting Disorder
☐ Autoimmune Disorder	☐ Hepatitis type:_____	☐ Migraines	☐ DVT
☐ BPH	☐ HIV	☐ Multiple Sclerosis	☐ Hemophilia
☐ Cancer- Breast	☐ High cholesterol/lipids	☐ Parkinson's Disease	☐ Narcotic use > 6 months
☐ Cancer – Lung	☐ Hypertension/High BP	☐ Peripheral Neuropathy	☐ Problems w/ Anesthesia
☐ Cancer- Renal	☐ Irritable Bowel Syndrome	☐ Pituitary tumor	☐ Pulmonary Embolism
☐ Cancer- Colon	☐ Heart Attack	☐ Seizure Disorder	☐ Other:
☐ Cancer- Prostate	☐ Nasal Allergies	☐ Spinal Cord Injury	
☐ Cataracts	☐ Osteoarthritis	☐ TIA	
☐ COPD	☐ Osteoporosis	☐ Traumatic Brain Injury	**Please list any other diagnosis not on this list:**
	☐ Renal Disease		
☐ Depression	☐ Rheumatoid Arthritis	☐ Trigeminal Neuralgia	
☐ Diabetes - Type 1	☐ Sleep Apnea		
☐ Diabetes - Type 2	☐ Thyroid Disease: high/low		
☐ Fibromyalgia	☐ Vision loss		

PAST SURGICAL HISTORY: ☐ **NO PREVIOUS SURGERIES**

Year of surgery:	**Type of surgery:**

If you require more room, please write surgeries on separate piece of paper and attach.

Patient Name: _____ DOB: _____/_____/_____ (mm/dd/yyyy)

ALLERGIES: ☐ No known drug allergies ***List medication, food, and environmental allergies***

Allergic to:	**Reaction:**

If you require more room, please write allergies on separate piece of paper and attach.

CURRENT MEDICATIONS: ***☐ NONE***

Medication name & dose *Example: Atenolol 50mg*	**How often** *Example: one tab daily, one tab twice daily, two tabs at bedtime*

If you require more room, please list your medications, doses & frequency on a separate sheet of paper and attach.

SOCIAL HISTORY/ADDITIONAL INFORMATION:

Tobacco use:	☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker **Passive Smoke Exposure** ☐ Yes ☐ No
Alcohol Use	☐ No ☐ Yes, Type:_____ How many drinks per day _____
Recreational Drug Use:	☐ No ☐ Yes, Type: _____ How often _____
Employment Status:	☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Self-employed What is or was your occupation: _____
Marital Status:	☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed
Handedness: ☐ Right-hand dominant ☐ Left-hand dominant ☐ Ambidextrous	Height _____ Weight: _____ lbs.

Patient Name: _____ DOB: _____/_____/_____ (mm/dd/yyyy)

FAMILY HISTORY: ☐ ***UNKNOWN*** ☐ ***ADOPTED*** ☐ ***NO FAMILY HISTORY OF CHRONIC DISEASE***
√ the diagnosis that apply for each of your immediate family members:

Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism	☐ Alcoholism
☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia	☐ Anemia
☐ Angina	☐ Angina	☐ Angina	☐ Angina	☐ Angina	☐ Angina	☐ Angina	☐ Angina
☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis
☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma
☐ Birth Defects	☐ Birth Defects	☐ Birth Defects	☐ Birth Defects	☐ Birth Defects	☐ Birth Defects	☐ Birth Defects	☐ Birth Defects
☐ Blood Clots	☐ Blood Clots	☐ Blood Clots	☐ Blood Clots	☐ Blood Clots	☐ Blood Clots	☐ Blood Clots	☐ Blood Clots
☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease	☐ Bowel Disease
☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer	☐ Breast Cancer
☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer	☐ Cervical Cancer
☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer	☐ Colon Cancer
☐ Depression	☐ Depression	☐ Depression	☐ Depression	☐ Depression	☐ Depression	☐ Depression	☐ Depression
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems	☐ Growth/ Development Problems
☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP	☐ Hypertension/ High BP
☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol
☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease
☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease	☐ Liver Disease
☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer	☐ Lung Cancer
☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer	☐ Melanoma/ Skin Cancer
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
☐ Other Cancer	☐ Other Cancer	☐ Other Cancer	☐ Other Cancer	☐ Other Cancer	☐ Other Cancer	☐ Other Cancer	☐ Other Cancer
☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer	☐ Ovarian Cancer
☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care	☐ Psychiatric Care
☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease	☐ Respiratory disease
☐ Seizures	☐ Seizures	☐ Seizures	☐ Seizures	☐ Seizures	☐ Seizures	☐ Seizures	☐ Seizures
☐ Severe allergies	☐ Severe allergies	☐ Severe allergies	☐ Severe allergies	☐ Severe allergies	☐ Severe allergies	☐ Severe allergies	☐ Severe allergies
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease	☐ Thyroid Disease
☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer	☐ Uterine Cancer

This information is true and complete to the best of my knowledge.

_____ _____

Signature **Date**

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PATIENT DEMOGRAPHICS FORM

Patient's First _____ MI _____ Last _____

Preferred Name _____ Email Address: _____

DOB_____/_____/_____ (mm/dd/yyyy) Age _____ SSN _____-____-_____ Sex ϒ Male ϒ Female

Mailing Address _____

City_____ State _____ Zip Code _____-_____

Best Phone # (_____) _____-_____ ϒ Home ϒ Cell

Alt. Phone # (_____) _____- _____ ϒ Home ϒ Cell

Cell OK to Text ϒ Yes ϒ No

Marital Status**:** ϒ Married ϒ Single ϒ Divorced ϒ Widowed ϒ Other

Referring Provider _____ Phone# (____) _____-_____

Primary Care Provider _____ Phone# (____) _____-_____

If you were referred by a different source than you PCP or referring, please indicate how you found our practice:

ϒ Friend/Family ϒ Internet/Website ϒ Other _____

Emergency Contact Name _____ Ph# (_____) _____-_____ Relationship_____

Pharmacy Preference _____ Address: _____

City: _____ Zip_____ Ph# (_____) _____-_____Fax: (____) ____-_____

The following questions are required for "Meaningful Use", a federal mandate established by CMS. These categories were established by CMS, not by our office. These questions will not influence your medical care. These statistics are reported to CMS.

Preferred Language:

ϒ English ϒ French ϒ German ϒ Vietnamese ϒ Mandarin ϒ Spanish ϒ Other_____

Race:

ϒ Caucasian ϒ American Indian ϒ Asian ϒAsian Indian ϒ Black or African American ϒ European ϒ Filipino ϒ Japanese
ϒ Korean ϒ Native Hawaiian or other Pacific Islander ϒ Other

Ethnicity:

ϒ Hispanic or Latino ϒ Non-Hispanic or non-Latino ϒ Other _____

Release: I hereby consent to the release of information provided to, or generated by CBSI, to my PCP, referring provider, psychologist, attorney, therapist, agency or any other party with a bonafide, pertinent interest, via verbal, written, or fax/email/protected copied disc for communication. A copy or scanned image of my signature shall be as valid as the original.

Patient Signature _____ Date _____

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Print Name: _____

Date of Birth: ____/_____/_____

******REQUIRED*******

Acknowledgement of Privacy Practices

By signing below, I hereby acknowledge that I have received a copy of Colorado Brain & Spine Institute's Notice of Privacy Practices as of the date set forth below.

_____ ____/_____/_____
Signature Today's date

Acknowledgement of Practice Policies

By signing below, I hereby acknowledge that I have received and agree to abide by the Practice Policies of Colorado Brain & Spine Institute.

_____ ____/_____/_____
Signature Today's date

The following individuals can have both written and verbal access to any of my medical records and information pertaining to my care:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____None, please do not share my information outside of policy guidelines.

_____ ____/_____/_____
Signature Today's date