Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Legal Sex*: ____ 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.

***Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**

Reason for today's visit:

Please be aware that the name and sex you have listed on your insurance

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

If Relevant: 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: _____

If Relevant: 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 Constipation
□Y□N Diarrhea
□Y□N Black/Tarry Stools
□Y□N Decreased Appetite
□Y□N Yellow Skin
□Y□N Trouble Swallowing
□Y□N Change in Bowels
□Y□N Vomiting Blood
□Y□N Bowel Incontinence
□Y□N Rectal Pain
□Y□N Heartburn
□Y□N Painful Swallowing
□ Other:

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: _____

ColumbiaDoctors | *Orthopedics*

Additional Orthopedic Department Form

Office Use Only
MRN #: _____ Age: _____ Height: _____
Weight: _____ Pulse: _____ BP: _____
BMI: _____

Name of person completing form: _____ Relationship (if not patient): _____

Referring provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Primary care provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Reason for today's visit: _____

Which side hurts? ☐ *Left* ☐ *Right* ☐ *Both* How long has your reason for today's visit been going on? _____

How did it start? _____

Hand dominance: ☐ *Left* ☐ *Right*

Pain description: ☐ *Dull* ☐ *Sharp* ☐ *Tingling* ☐ *Other:* _____

When does pain occur? ☐ *At rest* ☐ *With activity* ☐ *At night* ☐ *Other*: _____

Rate pain: *(Check box)*

No pain	1	2	3	4	5	6	7	8	9	10	Most extreme
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

What reduces the pain? ☐ *Medicine* ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Elevation*

Your problem has: ☐ *Improved* ☐ *Worsened*

Any other symptoms associated with the current problem? _____

Does your home have: *(Check all that apply)* ☐ *1 story* ☐ *2 stories* ☐ *3+ stories* ☐ *Entrance steps* ☐ *Elevator*

Do you take public transportation? ☐ *Y* ☐ *N*

Do you exercise regularly? ☐ *Y* ☐ *N* Are you involved in organized sports? ☐ *Y* ☐ *N*

Required Information:

Did this injury happen while working? ☐ *Yes* ☐ *No* Does this injury relate to an auto accident? ☐ *Yes* ☐ *No*

Is this injury related to a pending lawsuit? ☐ *Yes* ☐ *No*

_____ _____

Patient Signature Date