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: _____

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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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