ColumbiaDoctors

Pediatric New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Home Phone: _____ Mobile Phone: _____
Preferred (circle) : Home / Cell Email: _____ Sex: _____

Primary Pediatrician: _____ Phone: _____
Pediatrician Address: _____
Referring Provider: _____ Phone: _____
Referring Address: _____
Preferred Pharmacy: _____ Phone: _____
Preferred Pharmacy Address: _____

Parent 1 Name: _____ DOB: _____ Phone: _____ Email: _____
Address: _____
Occupation: _____ Marital Status: _____ Spouse: _____
Parent 2 Name: _____ DOB: _____ Phone: _____ Email: _____
Address: _____
Occupation: _____ Marital Status: _____ Spouse: _____

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

Columbia University, NewYork-Presbyterian and Weill Cornell Medicine 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.

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

☐ 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.**

Name: DOB:

ColumbiaDoctors

Medical and Social History

Reason for today's visit:

Is patient adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*

Which pregnancy is patient? _____ Birth weight: _____ Born by: □ C-Section □ Vaginal Delivery

Weeks' gestation at birth? _____ If C-section, why? _____

Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? □ Y □ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

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

Medication Name	Dose	Medication Name	Dose

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

Procedure/ Hospitalization	Date	Reason	Complications

Has the patient EVER had any of the following?

Anemia/Bleeding tendency	□ Y	□ N	Ear/Nose/Throat	□ Y	□ N
Asthma/Breathing problems	□ Y	□ N	Eczema/Skin disorder	□ Y	□ N
Behavioral problems	□ Y	□ N	Eye Disorder	□ Y	□ N
Blood Transfusion	□ Y	□ N	Growth disorder	□ Y	□ N
Bowel/Stomach problems	□ Y	□ N	Heart disorder/defect	□ Y	□ N
Cancer/Leukemia	□ Y	□ N	Kidney/Bladder problems	□ Y	□ N
Chicken Pox/Shingles	□ Y	□ N	Liver disease	□ Y	□ N
Developmental disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid disorder	□ Y	□ N

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

Name: DOB: ColumbiaDoctors

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

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

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Patient Social History

Does anyone living in your home smoke? □ Y □ N Do you have pets? □ Y □ N

Do you smoke? □Y □N □Never If Y, Packs/day _____ If N, previously? □Y □N Yrs smoked ____ Packs/day ___

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

For Females: Menses? □Y □N If Y, at what age? _____

Review of Systems

Please indicate ALL that the patient has experienced within the past 6 – 12 months.

Constitutional

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

Head, Eyes, Ears, Nose, and Throat

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

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

Name: DOB:

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Respiratory

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

Gastrointestinal

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	□Y□N	□ Other:	
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	□Y□N		

Neurological

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	□Y□N	□ Other:	
Poor Coordination	□Y□N	Burning Sensation	□Y□N	Fainting (Syncope)	□Y□N		

Musculoskeletal

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

Genitourinary

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	□Y□N	□ Other:	
Urinary Urgency	□Y□N	Itching- Genital	□Y□N	Vaginal Bleeding	□Y□N		
Painful Urination	□Y□N	Change in Libido	□Y□N	Irreg. Monthly Cycles	□Y□N		

Integumentary

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	□Y□N	□ Other:	

Psychiatric

Depression	□Y□N	Anxiety	□Y□N	□ Other:	

Hematologic/Lymphatic

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

Endocrine

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

OFFICE USE ONLY:

Provider Signature: _____ Date: _____

Additional Pediatric Orthopedic Information:

Please answer ALL QUESTIONS to the best of your ability

OFFICE USE ONLY

Name: _____ Age: ____

MRN# _____

Height: _____ Weight: _____ BP: _____

Temp: _____ If female, age of 1st menses? _____

CHIEF COMPLAINT

Reason for today's visit: _____

Symptoms/complaints & date of onset: _____

_____

_____

Pain severity: scale of 1 (no pain) to 10 (worst pain imaginable). Circle number below:

1 2 3 4 5 6 7 8 9 10

Pain is (Circle): Dull? Sharp? Tingling? Other: _____ Pain occurs? (Circle) At rest? With activity? At night?

What do you use to reduce the pain? (Circle): Medicine? Ice? Heat? Rest? Elevation?

Is problem improving, worsening or stable? _____

Other symptoms associated with the current problem? _____

_____

Is there a family history of this problem? _____

If this is an injury, how did it occur? _____

_____

Have you seen any other doctors (including in an ER) for this? If yes, whom, when, what treatment was given?

_____

_____

_____

FAMILY HISTORY

Patient's Mother's health: _____Father's health: _____

Patient's Sister/Brother's health: _____

Patient's Sister/Brother's health: _____

SOCIAL HISTORY

What is your child's grade in school _____ N/A _____

Do they attend a special needs facility (specify)_____

Languages spoken at home (circle all that apply): English Spanish Other_____

Who lives at home with you? _____

Frequency of Exercise/Organized Sports (circle): Daily Weekly Monthly Gym Class Only Rarely/ Never

Specific type of exercise/ sports: _____

_____

Describe any braces or orthotics your child uses including pattern of use: _____ _____

_____

Does your child receive:

Physical Therapy? No Yes Frequency _____ School based? Y N

Speech Therapy? No Yes Frequency _____ School based? Y N

Occupational Therapy? No Yes Frequency _____ School based? Y N

Is child enrolled in Early Intervention or Birth to 3? Y N

DEVELOPMENTAL DATA

At what age did patient first: Sit:_____ Stand_____ Walk? _____

Special concerns with development? _____

_____

_____

_____

Reviewed by: _____ ,**M.D.** **Date**: _____

PLEASE LIST ALL DOCTORS/PROVIDERS TO WHOM WE SHOULD SEND A REPORT

NAME	SPECIALTY	ADDRESS	PHONE NUMBER

Parent/Guardian signature: _____ Date:_____

Scan Folder: Registration Form

Revised 1/5/16

NAME:_____ **DATE:** _____

FILLED OUT BY:_____ **RELATIONSHIP TO PATIENT:**_____

1. Chief complaint: Spinal Deformity: ☐ Scoliosis ☐ Kyphosis ☐ Spondylolisthesis ☐ Other _____
   (check all that apply): ☐ Neck pain Arm: ☐ Pain ☐ Numbness ☐ Weakness
   ☐ Back pain Leg: ☐ Pain ☐ Numbness ☐ Weakness

2. How was your spinal deformity discovered? _____

3. Do you know your present curve measurement(s)? _____

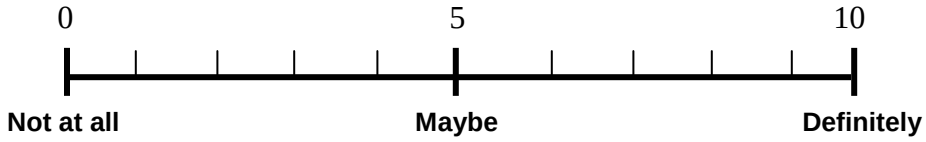
4. Growth in the past 6 months_____
   Height of Mother:_____ Father:_____ Siblings:_____

5. Does the patient have numbness or weakness in his/her legs? ____ Yes ____ No

6. Are there any problems with loss of bowel or bladder control? ____ Yes ____ No

7. Reason(s) for seeking treatment at this time: ☐ progressive deformity ☐ pain ☐ can't stand straight
   ☐ I don't like the appearance of my back/waistline ☐ Other: _____

8. If recommended, please rate how interested you are in having surgery to treat your problem:



Is there any other information that the doctor should be aware of?

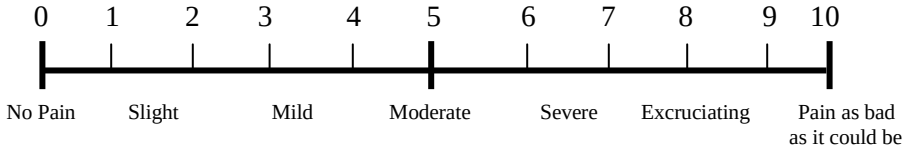
_____

_____

_____

_____

IF THERE IS SPINAL PAIN PRESENT, HOW WOULD YOU RATE IT? (**circle number)**



01. Pain Intensity
- ◯ I can tolerate the pain I have without having to use pain killers.
- ◯ The pain is bad but I manage without taking pain killers.
- ◯ Pain killers give complete relief from pain.
- ◯ Pain killers give moderate relief from pain.
- ◯ Pain killers give very little relief from pain.
- ◯ Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing, etc.)
- ◯ I can look after myself normally without it 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 everyday in most aspects of self care.
- ◯ I do not get dressed, wash with difficulty and stay in bed.

03. 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.

04. Walking
- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me walking more than 1 mile.
- ◯ Pain prevents me walking more than 1/2 mile.
- ◯ Pain prevents me walking more than 1/4 mile.
- ◯ I can only walk using a stick or crutches.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting
- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting more than one hour.
- ◯ Pain prevents me from sitting more than thirty minutes.
- ◯ Pain prevents me from sitting more than ten minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing
- ◯ I can stand as long as I want without extra pain.
- ◯ I can stand as long as I want but it gives extra pain.
- ◯ Pain prevents me from standing more than one hour.
- ◯ Pain prevents me from standing more than thirty minutes.
- ◯ Pain prevents me from standing more than ten minutes.
- ◯ Pain prevents me from standing at all.

07. Sleeping
- ◯ Pain does not prevent me from sleeping well.
- ◯ I can sleep well only by using tablets.
- ◯ Even when I take tablets I have less than six hours sleep.
- ◯ Even when I take tablets I have less than four hours sleep.
- ◯ Even when I take tablets I have less than two hours sleep.
- ◯ Pain prevents me from sleeping at all.

08. Employment/Homemaking
- ◯ My normal homemaking/job activities do not cause pain.
- ◯ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ◯ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g. lifting, vacuuming).
- ◯ Pain prevents me from doing anything but light duties.
- ◯ Pain prevents me from doing even light duties.
- ◯ Pain prevents me from performing any job or homemaking chores.

09. Social Life
- ◯ My social life is normal and gives 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., dancing, etc.).
- ◯ Pain has restricted my social life and I do not go out as often.
- ◯ Pain has restricted my social life to home.
- ◯ I have no social life because of pain.

10. Traveling
- ◯ I can travel anywhere without extra pain.
- ◯ I can travel anywhere but it gives extra pain.
- ◯ Pain is bad but I manage journeys over two hours.
- ◯ Pain restricts me to journeys less than one hour.
- ◯ Pain restricts me to short journeys under thirty minutes.
- ◯ Pain prevents me from traveling except to the doctor or hospital.

****

Please take time to review the questionnaire for completeness.
Your complete medical information is very important to us!
Thank you!

Patient/Parent Signature	Date	Physician Signature	Date

NAME **DATE OF BIRTH** **DATE COMPLETED**

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

NAME **DATE OF BIRTH** **DATE COMPLETED**

PATIENT HEALTH QUESTIONNAIRE-8 (PHQ-8)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _0_ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐