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SPINE QUESTIONNAIRE: CERVICAL

Patient's Last Name: _____ First: _____ Age: _____

Referring Physician: _____

Primary Care Physician: _____

Describe your spine pain (including date of onset, any related injury/accident): _____

_____

_____

Which arm is more painful? ☐ Right arm ☐ Left arm

Do you have any of the following (check all that apply)?

☐ Arm weakness ☐ Difficulty writing ☐ Hand clumsiness

☐ Balance problems ☐ Difficulty walking ☐ Loss of bladder/bowel control

Rate your neck pain: ☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Worst pain ever

Rate your arm pain: ☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Worst pain ever

Describe your pain (check all that apply):

☐ Dull ☐ Stabbing ☐ Burning ☐ Occasional ☐ Pain at night

☐ Sharp ☐ Electrical ☐ Aching ☐ Constant ☐ Pain during activities

What position/activity makes the pain worse (check all that apply):

☐ Overhead activity ☐ Repetitive motion ☐ Bending ☐ Lifting ☐ Other _____

What position/activity makes the pain better (check all that apply):

☐ Lying down ☐ Stretching ☐ Resting ☐ Other _____

PREVIOUS TREATMENT(S)

Please indicate previous treatment(s) you have received:

Physical Therapy ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Epidural Injections ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Back Surgery ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Treatment	Better	Same	Worse
Ice/Heat			
Corset/Brace			
Exercise			
Chiropractic			
Traction			
Biofeedback			
Neurostimulator			
Facet Injections			
Acupuncture/Pressure			
Other			

Please list all pain medications: _____

_____

DIAGNOSTIC TESTS

Please indicate which diagnostic tests you have undergone for your problem:

MRI Date: _____ Discogram Date: _____

X-Ray Date: _____ EMG Date: _____

CT Scan Date: _____ Myelogram Date: _____

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SPINE QUESTIONNAIRE: LUMBAR

Patient's Last Name: _____ First: _____ Age: _____

Referring Physician: _____

Primary Care Physician: _____

Describe your spine pain (including date of onset, any related injury/accident): _____

_____

_____

_____

Which leg is more painful? ☐ Right leg ☐ Left leg

Do you have any of the following (check all that apply)?

☐ Leg weakness ☐ Difficulty walking ☐ Loss of bladder/bowel control

Rate your back pain: ☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Worst pain ever

Rate your leg pain: ☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Worst pain ever

Describe your pain (check all that apply):

☐ Dull ☐ Stabbing ☐ Burning ☐ Occasional ☐ Pain at night

☐ Sharp ☐ Electrical ☐ Aching ☐ Constant ☐ Pain during activities

What position/activity makes the pain worse (check all that apply):

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other _____

What position/activity makes the pain better (check all that apply):

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other _____

PREVIOUS TREATMENT(S)

Please indicate previous treatment(s) you have received:

Physical Therapy ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Epidural Injections ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Back Surgery ☐ Yes ☐ No ☐ Date(s):_____
☐ Helped ☐ No help ☐ Made pain worse

Treatment	Better	Same	Worse
Ice/Heat			
Corset/Brace			
Exercise			
Chiropractic			
Traction			
Biofeedback			
Neurostimulator			
Facet Injections			
Acupuncture/Pressure			
Other			

Please list all pain medications:_____

_____

DIAGNOSTIC TESTS

Please indicate which diagnostic tests you have undergone for your problem:

MRI Date: _____ Discogram Date: _____

X-Ray Date: _____ EMG Date: _____

CT Scan Date: _____ Myelogram Date: _____

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SPINE QUESTIONAIRE

PAIN LEVEL

Please circle the number on the line below to describe your pain level with the last week.

Back/Neck:	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Possible Pain**
Left Leg/Arm:	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Possible Pain**
Right Leg/Arm	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Possible Pain**

CONDITION

Please circle the letter that best represents your condition over the last week:

1) PAIN INTENSITY
A. I have no pain at the moment
B. The pain is mild at the moment
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain is severe but comes and goes
F. The pain is severe and does not vary much

2) PERSONAL CARE (washing, dressing, etc.)
A. I can look after myself without causing extra pain
B. I can look after myself normally, but it causes extra pain
C. It is painful to look after myself and I am slow and careful
D. I need some help, but manage most of my personal care
E. I need help everyday in most aspect of self-care
F. I do not get dressed, I wash with difficulty and stay in bed

3) LIFTING
A. I can lift heavy objects without extra pain
B. I can lift heavy objects, but it causes extra pain
C. Pain prevents me from lifting heavy objects off the floor, but if conveniently positioned, I can lift them
D. Pain prevents me from lifting heavy weights, but I can manage conveniently-positioned light/medium weights
E. I cannot lift or carry anything at all

4) WALKING
A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than 1 mile
C. Pain prevents me from walking more than 1/2 mile
D. Pain prevents me from walking more than 100 yards
E. I can only walk using a cane or crutches
F. I am in bed most of the time and have to crawl to the toilet

5) SITTING
A. I can sit in a chair as long as I want to
B. I can sit in my favorite chair as long as I want to
C. Pain prevents me from sitting more than 1 hour
D. Pain prevents me from sitting more than 1/2 hour
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all

6) STANDING
A. I can stand as long as I want to without extra pain
B. I can stand as long as I want to, but it gives me extra pain
C. Pain prevents me from standing more than 1 hour
D. Pain prevents me from standing more than 1/2 hour
E. Pain prevents me from standing more than 10 minutes
F. Pain prevents me from standing at all

7) SLEEPING
A. My sleep is never disturbed by pain
B. My sleep is occasionally disturbed by pain
C. Because of pain, I get less than 6 hours of sleep
D. Because of pain, I get less than 4 hours of sleep
E. Because of pain, I get less than 2 hours of sleep
F. Pain prevents me from sleeping at all

8) SEX LIFE
A. My sex life is normal and causes no extra pain
B. My sex life is normal, but causes some extra pain
C. My sex life is nearly normal, but is very painful
D. My sex life is severely restricted because of pain
E. My sex life is nearly absent because of pain
F. Pain prevents any sex at all

9) SOCIAL LIFE
A. My social life is normal and causes me no extra pain
B. My social life is normal, but causes some extra pain
C. Pain has no significant effect on my social life apart from limiting my more physical/energetic interests
D. Pain has restricted my social life; I don't go out as often
E. Pain has restricted my social life to my home
F. I have no social life because of pain

10) TRAVELING
A. I can travel anywhere without pain
B. I can travel anywhere, but it gives me extra pain
C. Pain is bad, but I manage journeys over 2 hours
D. Pain restricts me to journeys of less than 1 hour
E. Pain restricts me to short, necessary journeys under 30 min

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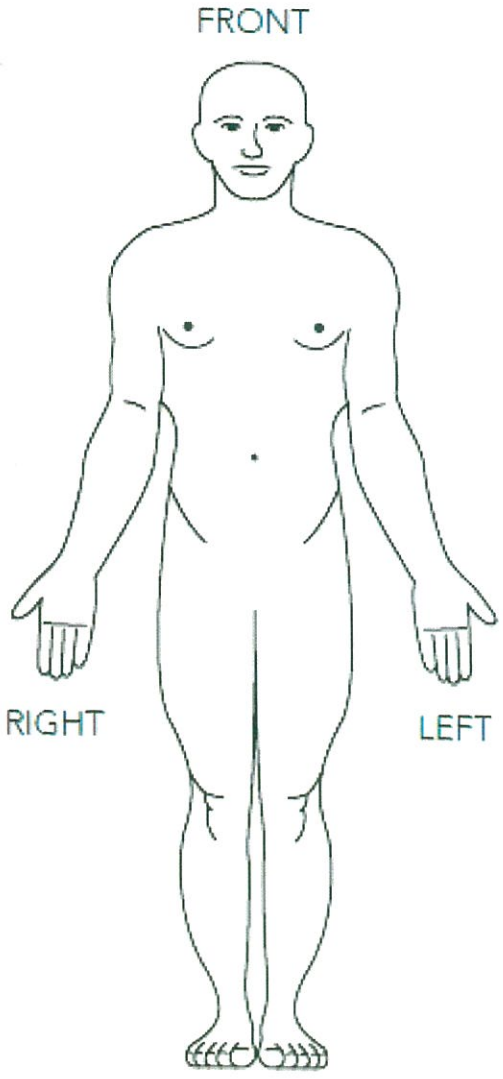
SPINE QUESTIONAIRE

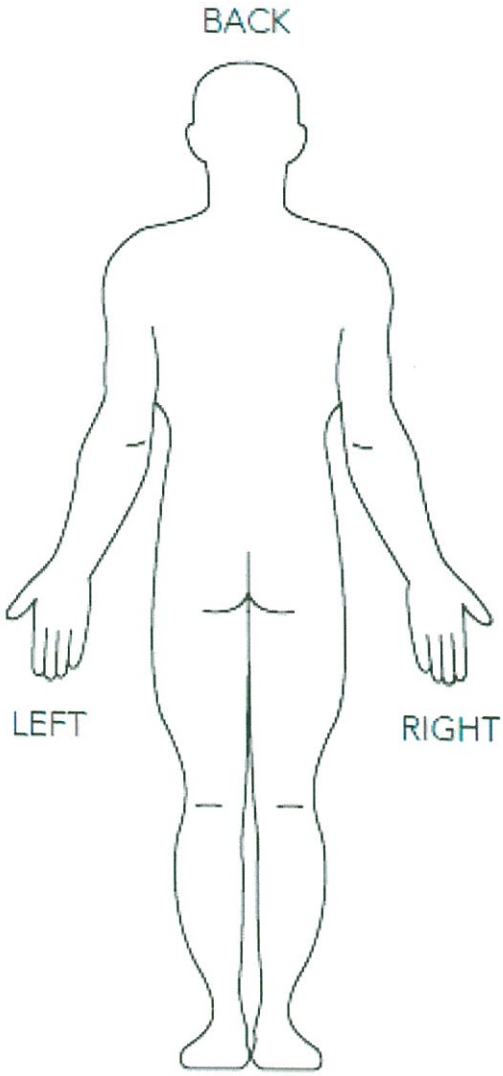
Height: _____ Weight: _____ Age: _____

SENSATION

Please mark the areas of the body where you feel the described sensations. Please use the appropriate symbol to mark the areas of radiating pain, and include all affected areas.

Numbness: == Pins & Needles: OO Burning: XX Stabbing: // Chronic Ache: ZZ





How much pain do you have now (circle one number)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**

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SPINE PATIENT HEALTH HISTORY

Height: _____ Weight: _____

MEDICATIONS

Please list any medication(s) you are currently taking including prescribed medications, vitamins, supplements and over-the-counter medications.

Medication	Dosage/Directions	Problem Being Treated	Prescribing Physician

ALLERGIES

Please list all medical allergies and tell us how you react to them.

Allergy	Reaction

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to adhesive tape? ☐ Yes ☐ No

Are you allergic to contrast dye? ☐ Yes ☐ No

Are you allergic to metal? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please check all conditions you have now, or have had in the past.

CARDIOVASCULAR
- ☐ Arrhythmia/Irregular Heartbeat
- ☐ Blood Clot/DVT (Deep Vein Thrombosis)
  Date Occurred: _____
- ☐ Heart Disease/Coronary Artery Disease
- ☐ High Cholesterol/Hyperlipidemia
- ☐ Pacemaker
- ☐ Hypertension/High Blood Pressure
- ☐ AICD (Automatic Implantable Cardioverter Defibrillator

CANCER
- ☐ Type: _____
- ☐ Chemotherapy
- ☐ Radiation

GENITOURINARY (Kidneys & Urinary Tract)
- ☐ Renal Disease
- ☐ Dialysis

NEUROLOGIC DISORDER (Brain & Nervous System)
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ MD (Multiple Sclerosis)
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Stroke/CVA—Date Occurred: _____

HEMATOLOGIC (Blood & Lymph Node)
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Clotting Disorders

METABOLIC (Endocrine, Hormones & Metabolic)
- ☐ Diabetes—Type I
- ☐ Diabetes—Type II
- ☐ Diabetes— Type Unknown
- ☐ Thyroid Dysfunction
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
- ☐ AIDS
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ MRSA (Methicillin Resistant Staph Aureus)
- ☐ Fibromyalgia
- ☐ Osteoporosis

PULMONARY (Lungs & Respiratory)
- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ PE (Pulmonary Embolism/Blood Clot in Lung)
  Date Occurred: _____
- ☐ Sleep Apnea
- ☐ Oxygen: Day/Night ____# liters

GASTROINTESTINAL
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis—Type Unknown
- ☐ Hernia

PSYCHIATRIC DISORDER (Mental Health)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

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SPINE PATIENT HEALTH HISTORY

PAST SURGICAL HISTORY

Please list all previous surgeries you have undergone.

Date	Type

FAMILY HISTORY

Check the boxes if a **blood relative** has been diagnosed with the following and indicate if s/he is deceased Y/N

	Relationship	Deceased	
☐ Anesthesia Problems		Y/N	☐ Family History Unknown
☐ Bleeding/Clotting Problems		Y/N	☐ No Significant family History
☐ Cancer: type _____		Y/N	

SOCIAL HISTORY

Do you currently use tobacco? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No Quantity per day: _____

Do you use marijuana? ☐ Yes ☐ No

Current/Former Illicit Drug Use: ☐ No ☐ Current: Type: _____ ☐ Past: Type: _____

Date Quit: _____

Are you currently employed? ☐ Yes ☐ No ☐ Retired ☐ Disabled, temporarily ☐ Disabled, permanently

Occupation: _____ Employer: _____

REVIEW OF SYMPTOMS

Please check all the conditions you are currently experiencing

CONSTITUTIONAL
- ☐ Unexpected weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

EYES
- ☐ Corrective lenses
- ☐ Blurred/double vision
- ☐ Eye pain
- ☐ Redness/watering

ENT
- ☐ Headache
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Earaches

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Murmurs

ALLERGIC
- ☐ Reaction to foods/environment

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Tightness
- ☐ Inspiration pain
- ☐ Snoring

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody/tarry stool

GENITOURINARY
- ☐ Difficult/painful urination
- ☐ Frequent urination
- ☐ Blood in urine

MUSCULOSKELTAL
- ☐ Joint pain
- ☐ Swelling
- ☐ Instability
- ☐ Stiffness
- ☐ Redness
- ☐ Muscle pain

SKIN
- ☐ Skin changes
- ☐ Poor healing
- ☐ Rash
  Location: _____
- ☐ Itching/redness

NEUROLOGIC
- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizure

PSYCHIATRIC
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

HEMATOLOGIC
- ☐ Easy bleeding
- ☐ Bruising

ENDOCRINE
- ☐ Excessive thirst/urination
- ☐ Heat/cold intolerable

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PATIENT REGISTRATION

Today's Date: _____

Legal Last Name: _____ First: _____ MI: ____ DOB: _____ Age: ____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____ ☐ Male ☐ Female

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: _____ Phone Number: _____ Relationship to Patient: _____

Race/Ethnicity: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? ☐ Friend/Family ☐ Physician ☐ Web ☐ TV ☐ Seminar ☐ School ☐ Other _____

If other than a physician, to whom may we thank for your referral? _____

Pharmacy Preference & Address: _____

MINOR INFORMATION

Responsible Party Name: _____ DOB: _____

Best Contact Number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____ Subscriber ID #: _____

Group # _____ Copay Amount: _____

Secondary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____ Member ID #: _____

Mailing Address (if different than above):

_____

INSURANCE AUTHORIZATION

Insurance Authorization and Assignment of Benefits:

I authorize the physicians and physicians' assistants at Colorado Springs Orthopaedic Group to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical and surgical benefit to Colorado Springs Orthopaedic Group.

_____

Patient or legally authorized individual signature Date

_____

Relationship to Patient

Section 1557, Affordable Care Act: Colorado Springs Orthopaedic Group, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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PATIENT ACKNOWLEDGEMENT FORM

We are pleased that you have chosen our group of specialists for your orthopaedic care. We are providing this information to you ahead of time to make your visit to our office as convenient as possible. Our office hours are 7:00am - 5:00pm Mon thru Friday.

REFERRALS

Based on your insurance plan, you may need a referral from your primary care physician (PCP) to see an orthopaedic physician. **Referrals are your responsibility** and are generated by your PCP's office, then submitted to the insurance company. Once approved, the insurance company will send you a copy—**Please bring a copy of your referral with you.** Your appointment will be rescheduled if you do not have a valid referral.

CO-PAYMENTS

These are the amounts that you have agreed with your insurance company to pay at each doctor's office visit.

INSURANCE CLAIMS

We will, for your convenience, submit your health claims using the insurance information that you have provided. If you change insurance coverage, please be sure to let us know when you come in. Be aware that many insurance plans include deductible amounts that are also your responsibility. Please be prepared to pay these amounts at your next visit.

LATE OR MISSED APPOINTMENT/ NO SHOW

We take great care in crafting the schedules of the physicians to accommodate as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive, but please understand that you may be asked to reschedule if we are unable to accommodate. Please call ahead and let us know if you will be late or need to reschedule an appointment at 719-632-7669.
Please be aware 2 "no show" appointments with any and all practice physicians within a rolling 12 month period will result in not being seen by any physician for 1 year from the date of the last "no show" unless you are willing to pay a $100 fee.

SURGERY

Be sure to ask for any appropriate "after care" instruction to take with you for later reference. Also be aware that many insurance companies have separate surgery deductible amounts that you must meet.

MEDICAL RECORDS

Your Driver's License or Government issued photo ID is required when picking up prescriptions and medical records. Please be aware that you may be charged for medical records requested.

SECTION 1557

Colorado Springs Orthopaedic Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

AUDUBON ORTHOTIC & PROSTHETIC SERVICES

If your Colorado Springs Orthopaedic Group provider refers you to AOPS for any orthotic or prosthetic care, please note that all paperwork included in this packet will be accepted and transmitted securely to AOPS. AOPS is a licensed DBA of Colorado Springs Orthopaedic Group. AOPS office hours are 7:30am—5:00pm Mon thru Friday.

ACKNOWLEDGEMENTS

_____ I acknowledge that I received a copy of the **CSOG Cancellation, No-Show & Late Patient Policy** from the Receptionist. I have read, understand and agree to the provisions of the policy.

_____ I acknowledge that I received the written **Notice of Privacy Practices from** the Receptionist. I have read, understand and agree to the provisions of the policy.

Patient or legally authorized individual signature

Date

Colorado Springs Orthopaedic Group

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AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION/ PATIENT ACKNOWLEDGEMENT FORM

Patient name:_____ DOB: _____

MY AUTHORIZATION

You may use or disclose the following health care information (check all that apply):

☐ My entire medical record maintained by Colorado Springs Orthopaedic Group

☐ My health information relating to the following treatment or condition _____

☐ My health information for the date(s): _____

You may disclose/request this health information to:

Full Name	Phone	Fax	Medical Records	RX pick up
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

I wish to be contacted in the following manner (check all that apply):

Primary Telephone:

☐ Leave message with detailed information

☐ Via text/ email communication—auto opt in (can always opt out)

☐ Leave message with call back number only

Secondary Telephone:

☐ Leave message with detailed information

☐ Leave message with call back number only

Email and Email Address: _____

MY RIGHTS

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office;

or

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature — Date — Time

_____

Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative, etc.)

STOP — For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other _____

_____

Colorado Springs Orthopaedic Group Employee Signature

Section 1557, Affordable Care Act: Colorado Springs Orthopaedic Group, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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FINANCIAL AGREEMENT

Thank you for choosing Colorado Springs Orthopaedic Group as your orthopedic provider. We are committed to delivering outstanding healthcare and customer service. The following is our current financial policy.

FOR PATIENTS WITH HEALTH INSURANCE

Colorado Springs Orthopaedic Group will submit an accurate claim to all contracted insurance as a courtesy to our patients. This will require information to be provided by the patient at each visit to ensure timely payment processing . Should the patient not provide accurate insurance data, the bill will become due by the patient at the time the insurance denies payment.

Colorado Springs Orthopaedic Group CANNOT waive copays, deductibles, coinsurance, or non-covered service amounts defined as patient responsibility under the terms of our contact with your health insurance. Patient copays are expected at the time of service.

FOR OUT-OF-NETWORK PATIENTS

In cases where Colorado Springs Orthopaedic Group is not recognized as a participating provider and considered Out-of-Network (OON), Colorado Springs Orthopaedic Group may elect to notify and provide full disclosure upon submission of a claim to the patient's insurance carrier that Colorado Springs Orthopaedic Group will offer a discount to the patient as their insured member. Colorado Springs Orthopaedic Group will bill the patient's insurance carrier its full charge and then discount the patient portion of the payment to usual and customary as defined by the insurance carrier. Should the patient's insurance carrier offer payment to Colorado Spring Orthopaedic Group at the discounted rate offered to the patient, Colorado Springs Orthopaedic Group will accept the payment from the insurer as payment in full. At no time, is Colorado Springs Orthopaedic Group charging two different prices for the same service, nor is pricing based on the fact than an insurance company may be paying for all or a part of the service rendered. This is not a waiver or a discount of any copayment, coinsurance or deductible amounts owed for services rendered and is not offered and should not be interpreted as an "inducement" to have services rendered.

I authorize Colorado Springs Orthopaedic Group and their billing company to negotiate, discuss, and in any other way, communicate with my insurance company in those areas relative to OON reimbursements, methodology used in OON negotiation and affair negotiation of final payment. I authorize Colorado Springs Orthopaedic Group and its billing company to accept or reject agreements, to enter into contracts binding upon final adjunction of claims and negotiations, and to act in whatever way necessary so as to accomplish that which is being undertaken.

FOR AUTO ACCIDENTS/LIABILITY PATIENTS

Colorado Springs Orthopaedic Group does not bill third party insurance.

PAST DUE ACCOUNTS

All patient responsible balances should be paid at the time the statement is received. After 90 days your account will be become delinquent. If the account remains delinquent, the patient will be unable to schedule any further appointments until the debt has been settled.

Thank you for your understanding of our financial policy. If you have any questions regarding this policy or you account, please contact our billing department at 719-867-9346 or email statements@csog.net.

I have read and understand the financial policy of the practice and I agree to its terms. I also understand that the terms may be amended by the practice.

Patient or legally authorized individual signature _____ Date _____

Printed name _____ Date of birth _____