1231 Lake Plaza Drive| Colorado Springs, CO | 80906 | (719) 955-0648

PATIENT INFORMATION

Name: _____ Date: ____/_____/_____

SS: _____ - ____ - _____ Sex: M / F Date of Birth: ____/_____/_____

Marital Status: Married / Partner / Single / Widowed Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer Name: _____ Work Phone: (_____) _____-_____

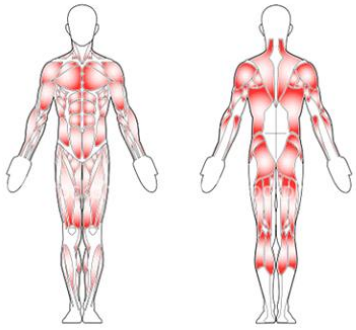
Emergency Contact Name: _____ Phone: (_____) _____-_____

Relationship to Emergency Contact: _____

Do you have a "Living Will" or an "Advance Directive? Yes_____ No_____

How did you hear about our office? Referred by: _____

Please Circle Areas of Complaint



Chief Complaint: _____

How long have you had this problem? When did it start?

_____

Name of other physician(s) or facilities who have seen you for this:

_____

Do any of your direct family members have a similar condition? ❑Yes ❑No
Relationship to affected family members (e.g. father, mother, etc.):

_____

If you complain of **knee pain**, please fill out any that apply. Leave blank if this does not apply:

❑ I am wheelchair-bound. I cannot walk at all due to my knee pain.
❑ I can only walk around my home from room to room. I need a wheelchair outside my home.
❑ I have other problems besides my knees that affect my walking. ❑Foot ❑Ankle ❑Hip ❑Back ❑Other
❑ I use a cane or walker when walking: ❑All of the time ❑Most of the time ❑Some of the time
❑ Because of my knee(s), I use a mobility scooter whenever they are available at department or grocery stores.
❑ Because of my knee(s), I find it difficult to walk over uneven terrain, hills, and slopes.
❑ Because of my knee(s), I find it difficult to walk on loose surfaces such as those with gravel or sand.
❑ Although my knee pain can get severe, I keep pushing through it when I need to get something done.
About how **long** can you **walk** before needing to rest due to your knee pain? _____ ❑minutes ❑hours

About how **far** can you **walk** before needing to rest due to your knee pain? _____ ❑blocks ❑miles

About how long can you **stand** before needing to rest due to your knee pain (minutes/hours)? _____

My knee pain reduces my sleep ❑Every night ❑_____ nights per week

❑ I have to use my arms to pull myself up from a chair, get out of the car, or get up from the toilet.
Because of my knee(s), getting up from the floor is ❑impossible ❑very difficult ❑somewhat difficult.
❑ Because of my knee condition, I find it difficult to twist, turn, or pivot.
❑ Because of my knee condition, I find it difficult to shower, bathe, and/or dry myself off.
❑ I think I have gained weight because my knee condition prevents me from exercising.

❑ I would like to lose weight, but I feel like my knee problem is holding me back.

In the space below, tell us anything you would like us to know about how the knee pain is affecting your life. Consider any other activities you would like to be able to do that are limited by your knee pain. Consider anything you feel that you might be missing out on because of your knee pain.

_____

_____

Please indicate whether you have a history of any of the following **common conditions**:

Constitutional	**Cardiovascular**	**Musculoskeletal**	**Hematologic**
❑ Overweight	❑ Hypertension	❑ Degenerated Disc	❑ Anemia
❑ Obese	❑ Hypotension	❑ Bulging/Herniated Disc	❑ Clotting Disorder
Eyes	❑ Hyperlipidemia	❑ Osteoarthritis	**Allergic**
❑ Wear Corrective Lenses	❑ Heart Disease	❑ Rheumatoid Arthritis	❑ Autoimmune Disease
❑ Glaucoma	❑ Myocardial Infarction	❑ Gout	**Men**
❑ Macular Degeneration	❑ Atrial Fibrillation	❑ Osteoporosis	❑ Erectile Dysfunction
❑ Cataracts	❑ Stroke	**Neurologic**	❑ Enlarged Prostate
Ears	❑ Varicose Veins	❑ Peripheral Neuropathy	**Female**
❑ Hearing Aid	❑ Deep Vein Thrombosis	❑ Vertigo	❑ Breast Cancer
Respiratory	❑ Pulmonary Embolism	❑ Epilepsy	**Psychiatric**
❑ Asthma	**Gastrointestinal**	❑ Multiple Sclerosis	❑ Dementia
❑ COPD	❑ GERD/Heartburn	❑ Parkinson's Disease	❑ Psychiatric Care
❑ On Oxygen	❑ Ulcer	**Endocrine**	❑ Psychiatric Illness
❑ Bronchitis	❑ Diverticulitis	❑ Hypoglycemia	❑ Alcoholism
	❑ Liver Disease	❑ Diabetes I (Childhood)	
	Genitourinary	❑ Diabetes II (Adult Onset)	
	❑ Kidney Disease	❑ Hypothyroidism	
	❑ Kidney Stones	❑ Hyperthyroidism	

Have you ever had **cancer**? ❑No. ❑Yes. What kind(s) if yes? _____

Have you ever had a **broken bone**? ❑No. ❑Yes. Which bone, what side? _____
Please list any **other conditions** in your health history that are not included above:

_____

Please indicate whether you have a history of any of the following **common surgeries**:

❑ Cataract Surgery	❑ Gall Bladder Removal	❑ Left Hip Replacement	❑ Fracture Surgery
❑ Tonsillectomy	❑ Colon Surgery	❑ Right Hip Replacement	❑ Thyroidectomy
❑ Stent	❑ Bariatric Procedure	❑ Left Knee Replacement	❑ Mastectomy
❑ Pacemaker	❑ Cervical Discectomy	❑ Right Knee Replacement	❑ Lumpectomy
❑ Angioplasty	❑ Cervical Fusion	❑ Left Knee Arthroscopic	❑ C-Section
❑ Coronary Bypass	❑ Lumbar Fusion	❑ Right Knee Arthroscopic	❑ Prostatectomy
❑ Appendectomy	❑ Lumbar Laminectomy	❑ Left Ankle Surgery	❑ Hysterectomy
	❑ Lumbar Discectomy	❑ Right Ankle Surgery	

Please list any **other surgeries** in your health history that are not included above:

_____

Medications: ❑ Check if you brought a complete list of medications.
Please list your medications below if you did not bring a complete list.

_____

Do you take any **blood thinners** or any of the ones below? ❑Yes. ❑No. Check those below that apply.
❑Warfarin/Coumadin ❑Aspirin ❑Clopidogrel/Plavix ❑Xarelto/Rivaroxaban ❑Eliquis ❑Pradaxa/Dabigatran
❑Ticagrelor/Brilinta ❑Effient/Prasugrel
Some patients who take blood thinners have blood work done to check blood clotting time.

<u>If applicable</u>, Last Test Date (blood clotting test): _____ Last result (if known): _____

Where was the test performed? _____

Allergies: Do you have allergies to any of the following? ❑No allergies.
❑Birds ❑Avian Proteins ❑Chicken ❑Eggs ❑Feathers ❑Shellfish ❑Iodine ❑Contrast media/dye
❑Cortisone ❑Lidocaine ❑Xylocaine ❑Bupivicaine ❑Penicillin ❑Codeine ❑Latex
❑ Check if you brought a list of allergies. Please list any other allergies below if you did not bring a list.

_____

Please indicate whether you have any of these **symptoms**:

Constitutional
- ❒ Fever
- ❒ Fatigue
- ❒ Sleep Issues
- ❒ Loss of Appetite
- ❒ Excessive Hunger
- ❒ Weight Gain
- ❒ Unexplained Weight Loss
- ❒ Night Sweats
- ❒ Check here if none of above.

Eyes
- ❒ Wear Glasses or Contacts
- ❒ Blurred Vision
- ❒ Double Vision
- ❒ Pain
- ❒ Redness
- ❒ Halos/Flashes
- ❒ Check here if none of above.

Ears
- ❒ Ringing in Ears (Tinnitus)
- ❒ Pressure in Ears
- ❒ Pain in the Ear
- ❒ Ear Discharge
- ❒ Hearing Loss
- ❒ Check here if none of above.

Mouth, Nose & Throat
- ❒ Stuffiness (Nasal
- ❒ Nose Bleeds (Epistaxis)
- ❒ Sinus Problems
- ❒ Dry Mouth
- ❒ Throat Sores
- ❒ Hoarseness
- ❒ Sore Throat
- ❒ Difficulty Swallowing
- ❒ Seasonal Allergies
- ❒ Check here if none of above.

Respiratory
- ❒ Shortness of Breath
- ❒ Cough
- ❒ Congestion
- ❒ Sputum
- ❒ Wheezing
- ❒ Check here if none of above.

Cardiovascular
- ❒ Chest Pain
- ❒ Chest Tightness
- ❒ Palpitations/Skipped Beats
- ❒ Heart Rhythm Problems
- ❒ Swelling in the Legs (Edema)
- ❒ Fainting (Syncope)
- ❒ Check here if none of above.

Gastrointestinal
- ❒ Nausea
- ❒ Vomiting
- ❒ Abdominal Pain
- ❒ Diarrhea
- ❒ Constipation
- ❒ Bowel Control Problem
- ❒ Indigestion
- ❒ Blood in Stool
- ❒ Heartburn
- ❒ Check here if none of above.

Genitourinary
- ❒ Incontinence
- ❒ Frequent Urination
- ❒ Urgent Urination
- ❒ Painful Urination
- ❒ Excessive Urination
- ❒ Blood in Urine
- ❒ Check here if none of above.

Skin/Integumentary
- ❒ Rash
- ❒ Skin Sores or Ulcers
- ❒ Itching
- ❒ Dry Skin
- ❒ Hair or Nail Changes
- ❒ Check here if none of above.

Musculoskeletal
- ❒ Joint Swelling
- ❒ Redness of Joints
- ❒ Stiffness
- ❒ Muscle Spasms
- ❒ Neck Pain
- ❒ Shoulder or Arm Pain
- ❒ Low Back Pain
- ❒ Hip Pain
- ❒ Ankle Pain
- ❒ Check here if none of above.

Neurologic
- ❒ Headaches
- ❒ Migraines
- ❒ Dizziness
- ❒ Nerve Pain
- ❒ Tingling or Numbness
- ❒ Seizures
- ❒ Tremor
- ❒ Difficulty of Speech
- ❒ Balance Problems
- ❒ Frequent Falls
- ❒ Coordination Problems
- ❒ Check here if none of above.

Endocrine
- ❒ Heat/Cold Insensitivity
- ❒ Breast Changes
- ❒ Hair Changes
- ❒ Excessive Thirst
- ❒ Check here if none of above

Hematologic/Lymphatic
- ❒ Ease of bruising
- ❒ Ease of bleeding
- ❒ Swollen Lymph Nodes
- ❒ Check here if none of above.

Allergic/Immunologic
- ❒ Environmental Allergies
- ❒ Food Sensitivities/Allergies
- ❒ Frequent Colds/Infections
- ❒ Check here if none of above

Psychological
- ❒ Depression
- ❒ Irritable/Mood Swings
- ❒ Memory Loss
- ❒ Anxiety
- ❒ Foggy Thinking
- ❒ Stress
- ❒ Check here if none of above.

Women
- Pregnant? ❒ Yes ❒ No
- ❒ Hot Flashes
- ❒ Breast Lump(s)
- ❒ Check here if none of above

WOMAC OSTEOARTHRITIS INDEX

Name: _____ ID: _____ Date: _____

PAIN

1. The following questions concern the amount of pain you are currently experiencing in your knees. For each situation, please enter the amount of pain you have experienced in the past 48 hours.

	None	Mild	Moderate	Severe	Extreme
A. Walking on a flat surface	0	1	2	3	4
B. Going up or down stairs	0	1	2	3	4
C. At night while in bed	0	1	2	3	4
D. Sitting or lying	0	1	2	3	4
E. Standing upright	0	1	2	3	4

STIFFNESS

2. How severe is your stiffness after first awakening in the morning?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

How severe is your stiffness after sitting, lying, or resting later in the day?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

PHYSICAL FUNCTION

3. The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 48 hours, in your knees.
What degree of difficulty do you have with?

	None	Mild	Moderate	Severe	Extreme
A. Descending (going down) stairs	0	1	2	3	4
B. Ascending (going up) stairs	0	1	2	3	4
C. Rising from sitting	0	1	2	3	4
D. Standing	0	1	2	3	4
E. Bending to floor	0	1	2	3	4
F. Walking on a flat surface	0	1	2	3	4
G. Getting in/out of car	0	1	2	3	4
H. Going shopping	0	1	2	3	4
I. Putting on socks/stockings	0	1	2	3	4
J. Rising from bed	0	1	2	3	4
K. Taking off socks/stockings	0	1	2	3	4
L. Lying in bed	0	1	2	3	4
M. Getting in/out of bath	0	1	2	3	4
N. Sitting	0	1	2	3	4
O. Getting on/off toilet	0	1	2	3	4
P. Heavy domestic duties (mowing. the lawn, lifting heavy grocery bags)	0	1	2	3	4
Q. Light domestic duties (such as tidying a room, dusting, cooking)	0	1	2	3	4

To Be Completed By Doctor: TOTAL SCORE: _____ / 96 = _____%

Insurance Information

Primary

Insurance Carrier: _____ Phone: _____
Policy Holder Name: _____Policy Holder DOB: _____
Policy Holder SS#: _____ Policy Number: _____
Group Number: _____ This is: Health Insur Auto Workers Comp Other

Secondary

Insurance Carrier: _____ Phone: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder SS#: _____ Policy Number: _____
Group Number: _____

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

CONSENT FOR TREATMENT
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Colorado Health and Wellness to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 719-955-0648. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I have received, read and understand Colorado Health and Wellness' Notice of Information Practices containing a complete description of the uses and disclosures of my health information. I understand that Colorado Health and Wellness has the right to change its Notice of Information Practices from time to time and that I may contact CHW at any time to obtain a current copy of the Notice of Information Practices. I have also read and voluntarily consent to treatment and release of information as indicated above.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

1231 Lake Plaza Drive | Colorado Springs, CO | 80906 | (719) 955-0648

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date: _____

Social Security #: _____ - _____ - _____

I hereby authorize Colorado Health and Wellness to use and disclose my protected health care information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review Colorado Health and Wellness' Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice had the right to change their privacy practices and that I may obtain any revised notices from Colorado Health and Wellness.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Colorado Health and Wellness is not required to agree to the request. If Colorado Health and Wellness agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____
(Patient, Parent, or Legal Guardian)

Date: _____ / ___ / _____

If signed by Patient's representative, state relationship to Patient:

_____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

• If you are unable to keep your appointments, please call 24 hours in advance to cancel your appointment. We will charge a fee of $50 for no show appointments.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Electronic Health Records Intake Form

In compliance with requirements for the government Quality Payment Program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Would you like us to send you an email with information on how to register for access to receive visit summaries?
❒ No, I decline access at this time. ❒ Yes, please send me an email.

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

For women over 50: Have you had a mammogram at any time in the past 15 months? Yes / No

If Yes to above: Date of last mammogram: ___/___/___ Side: ❒Right ❒Left ❒Both

Where study was performed: _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage (i.e. 15 mg)	Frequency (i.e. once a day, etc.)
Please use the back if you need more room.		

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____