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

Race & Ethnicity: Hispanic Non-Hispanic African American Other_____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

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

Preferred method of communication: Home Cell Email

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

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

Relationship to Emergency Contact: _____

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

Chief Complaint: (What brings you in today?

_____

_____

_____

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

_____

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

_____

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

_____

_____

_____

_____

Please list any **surgeries** in your health history:

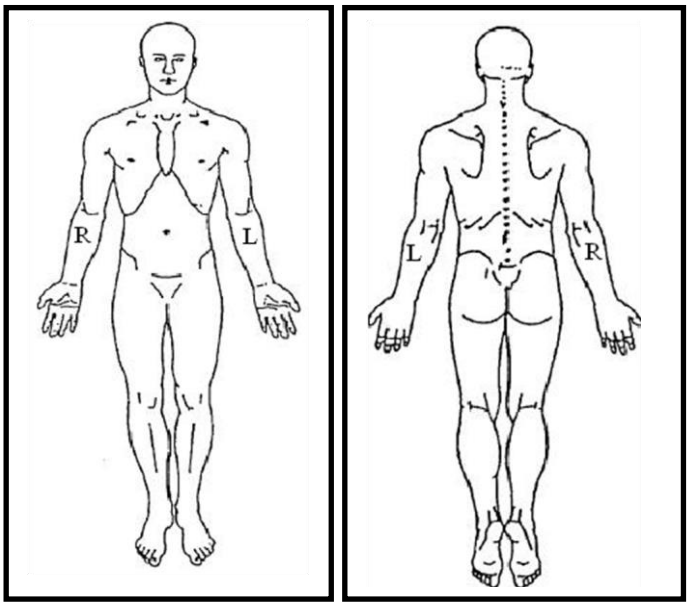
_____

_____

_____

Please Draw in your Pain, Numbness, Tingling and Weakness as Detailed as Possible.

Put a **P** where your have **PAIN**
Put a **N** where you have **NUMBNESS**
Put a **T** where you have **TINGLING**
Put a **W** where you have **WEAKNESS**
Put a **S** where you have **SWELLING**



On a scale of 1 – 10 please circle your level of **symptoms**: 1 5 10

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?

_____

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.

If applicable, 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.
❑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.

Diabetes:

I am diabetic: Yes or No I am Type 1 and/or Type 2 diabetic.

If yes, my diabetes is medically supervised: Yes or No

Congratulations! You have reached the last page of this tedious incoming paperwork. Below is a simple all-inclusive Symptom Chart. IF any of the symptoms are relevant to you, please place a check mark in the box. Our staff will review with you later.

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

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

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

Ears
- ❒ Ringing in Ears
- ❒ Pressure in Ears
- ❒ Pain in the Ear
- ❒ Ear Discharge
- ❒ Hearing Loss
- ❒ Check here if none

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

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

Cardiovascular
- ❒ Chest Pain
- ❒ Chest Tightness
- ❒ Palpitations/Skipped
- ❒ Heart Rhythm
- ❒ Swelling in the Legs
- ❒ Fainting (Syncope)
- ❒ Check here if none

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

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

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

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

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

Endocrine
- ❒ Heat/Cold
- ❒ 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

Allergic/Immunologic
- ❒ Environmental Allergies
- ❒ Food
- ❒ Frequent
- ❒ Check here if none of

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

Women

Pregnant? ❒ Yes ❒ No
- ❒ Hot Flashes
- ❒ Breast Lump(s)
- ❒ Other_____

Men
- ❒ Prostate
- ❒ ED
- ❒ Other_____

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 $75.00 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

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:

_____

Who would you like us to share your health information with?

Name:_____ Relationship_____

Name:_____ Relationship_____

Peripheral Neuropathy Symptoms Please rate how each item below is affected by your peripheral neuropathy.	None	Mild	Mild to Moderate	Moderate	Moderate to Severe	Severe
Walking Difficulty						
Balance Trouble						
Restless Legs						
Foot Numbness						
Leg Numbness						
Ulcers/Sores on Feet						
Sciatica						
Grip Strength						
Speed of Wound Healing						
Posture						
Holding Items (Telephone, etc.)						
Dressing (Buttons, Zippers, etc.)						
Pain if I Cough, Sneeze, or Bear Down						
Limited in Driving						
Cold Hands						
Cold Feet						
Diminished Hand or Arm Strength						
Diminished Foot, Ankle, or Leg Strength						

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

Constitutional
- ❑ Overweight
- ❑ Obese

Eyes
- ❑ Wear Corrective Lenses
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Cataracts

Ears
- ❑ Hearing Aid

Respiratory
- ❑ Asthma
- ❑ COPD
- ❑ On Oxygen
- ❑ Bronchitis

Cardiovascular
- ❑ Hypertension
- ❑ Hypotension
- ❑ Hyperlipidemia
- ❑ Heart Disease
- ❑ Myocardial Infarction
- ❑ Atrial Fibrillation
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Deep Vein Thrombosis
- ❑ Pulmonary Embolism

Gastrointestinal
- ❑ GERD/Heartburn
- ❑ Ulcer
- ❑ Diverticulitis
- ❑ Liver Disease

Genitourinary
- ❑ Kidney Disease
- ❑ Kidney Stones

Musculoskeletal
- ❑ Degenerated Disc
- ❑ Bulging/Herniated Disc
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Osteoporosis

Neurologic
- ❑ Peripheral Neuropathy
- ❑ Vertigo
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease

Endocrine
- ❑ Hypoglycemia
- ❑ Diabetes I (Childhood)
- ❑ Diabetes II (Adult Onset)
- ❑ Hypothyroidism
- ❑ Hyperthyroidism

Hematologic
- ❑ Anemia
- ❑ Clotting Disorder

Allergic
- ❑ Autoimmune Disease

Men
- ❑ Erectile Dysfunction
- ❑ Enlarged Prostate

Female
- ❑ Breast Cancer

Psychiatric
- ❑ Dementia
- ❑ Psychiatric Care
- ❑ Psychiatric Illness
- ❑ Alcoholism

Other
- ❑ HIV/AIDS
- ❑ Currently being treated for a bacterial infection