Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ☐

EFTA00295100

Columbia University
Medical Center

Physical Therapy

Patient Name _____ MRN # _____

When did your symptoms start? _____

Briefly describe your symptoms _____

How did your symptoms start? _____

Average pain intensity last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
Average pain intensity past week: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? (***please circle one***)

1 – Constantly (76% - 100% of the time) 2 – Frequently (51% - 75% of the time)
3 – Occasionally (26% - 50% of the time) 4 – Intermittently (0% - 25% of the time)

How much have your symptoms interfered with your daily activities? (***please circle one***)

1 – Not at all 2 – A little bit 3 – Moderately 4 – Quite a bit 5 – Extremely

How is your condition changing, since care at *this* facility? (***please circle one***)

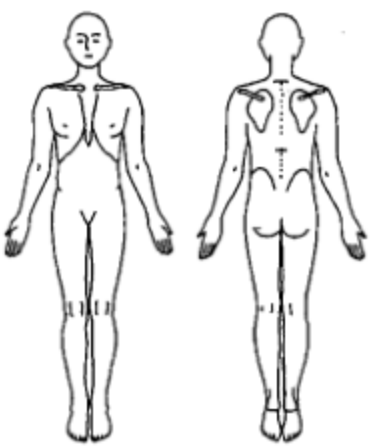
N/A – This is the initial visit 1 – Much worse 2 – Worse 3 – A little worse
4 – No change 5 – A little better 6 – Better 7 – Much better

In general, would you say that your overall health right now is…(***please circle one***)

1 – Excellent 2 – Very good 3 – Good 4 – Fair 5 – Poor

What makes it feel better? _____ What makes it feel worse? _____

Have you had any treatment for this problem? (***describe***): _____



Please draw your symptoms on the chart.
Key:
Pain: (XXXX) Numbness/tingling: (//////////)
Muscle Spasm: (ZZZZ) Radiating symptoms: (→→→)

Please rate your pain on a scale of 0-10.
(0=no pain, 10=requires Emergency Room visit):

Currently _____

At best, in the last 72 hours _____
At worst, in the last 72 hours _____

Are you allergic to latex? _____YES _____NO

Do you have any special equipment? (**canes, crutches, walker, exercise equipment**) _____

Do you do any regular exercise? If so, describe: _____

ColumbiaDoctors

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

For ColumbiaDoctors use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ColumbiaDoctors Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record

Revised March 2014

Patient Name: _____ **Unit #:** _____

Drug name	Dosage

Family History

Illness	Yes	Relative	Illness	Yes	Relative
diabetes			drinking		
stroke			breast cancer		
heart disease			colon cancer		
high blood pressure			ovarian cancer		
aneurysm			other		

Social History

Habits				
smoking	yes ___ no ___	packs per day _____	years _____	
alcohol	yes ___ no ___	drinks per day _____	years _____	
drug use	yes ___ no ___			

Personal Profile

marital status: married ___ single ___ widowed ___ divorced ___ number of children____

occupation: _____ education: _____

other: _____

Signature of patient: _____ **Date:** _____

Date reviewed by patient: _____

Physician signature: _____ **Date:** _____

Patient Name: _____ Unit #: _____

bruises, frequent			
enlarged lymph nodes			

Continue to page 3

Allergic/Immunologic	Yes	No	Notes
allergies			
drugs, other			
Skin			
new rashes/skin lesions			
Other Personal History			

Operations/ Hospitalizations

Reason	Date	Reason	Date

Injuries/Illnesses

Type	Date

Current Medications

Drug name	Dosage

Patient Name: _____ **Unit #:** _____

Continue to page 2

Gastrointestinal	Yes	No	Notes
severe abdominal pain			
diarrhea			
bloody stool			
nausea/vomiting			
constipation			
Genitourinary			
blood in urine			
painful urination			
urgency/frequency			
incomplete emptying			
painful intercourse			
For Females			
abnormal periods			
last menstrual cycle			
Musculoskeletal/Neurological			
muscle weakness			
trouble walking			
swelling			
stroke or seizures			
head, neck, or back injuries			
chronic pain			
"pins and needles" feeling			
loss of sensation/numbness			
headaches			
dizziness			
Psychiatric			
depression/anxiety			
psychiatric disorder			
sleep problems			
Endocrine/Renal			
dry skin			
abnormal thirst			
hot flashes			
diabetes			
adrenal or thyroid disease			
kidney disease/failure			
hepatitis/jaundice/cirrhosis			
Hematologic/Lymphatic			
anemia/low blood count			
bleeding ulcers			
sickle cell disease			

ColumbiaDoctors | *Neurological Surgery*

Patient Name: _____ Unit #: _____

Review of Systems	Please check (x) if any of the following apply to you now, in the past, or often.		
	Yes	No	Notes
Current weight: _____			
Height: _____			
weight loss/weight gain			
fever			
fatigue			
Eyes			
double vision			
spots before eyes			
vision changes			
dry eyes			
glaucoma/cataracts			
Ent/Mouth			
ear aches			
ringing in ears			
sinus problems			
sore throat			
mouth sores			
dental problems			
difficulty swallowing			
Cardiovascular			
painful breathing			
chest pain or shortness of breath			
atrial fibrillation or irregular heartbeat			
swelling of legs			
high cholesterol			
high blood pressure			
heart murmur/heart failure			
heart attack or angina			
Respiratory			
shortness of breath/ swollen ankles			
wheezing/cough			
spitting up blood			
tuberculosis (tb)			
smoked in the last year			

_____, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

UNIT # _____

MARKETING PATIENT SURVEY

Please take the time to fill out the following information, so we may better serve you and future patients. All information will be kept anonymous.

Patient Name: _____ (not required) Your Doctor: _____

1. Who was your source of referral or how did you find out about us? Please select all that apply and indicate below.
   - ☐ Family/Friend: _____
   - ☐ Physician: _____
   - ☐ Print Media: _____
   - ☐ Website/Search engine: _____
   - ☐ Social Media: _____
   - ☐ Other: _____
2. Did you visit our website (www.columbiancurosurgery.org)? If so, which page(s) or video(s) were helpful?
   - ☐ Doctor's Bio Page
   - ☐ Medical Conditions and Treatments Page
   - ☐ Specialties Page
   - ☐ Doctor's Video
   - ☐ Patient Testimonial Video
   - ☐ Blog
   - ☐ Other: _____
3. Did you visit a patient review site (i.e. Healthgrades.com) about our doctor before you came in?
   - ☐ Yes
     - If yes, which patient review website(s) did you visit?
       - ☐ Healthgrades.com ☐ Vitals.com ☐ RateMds.com ☐ Other : _____
   - ☐ No
4. Would it be ok for a representative from the marketing department to contact you for your opinion or feedback?
   - ☐ Yes ☐ Texts: (_____) _____-_____ ☐ Emails: _____
   - ☐ No

_____, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

UNIT # _____

PATIENT FINANCIAL OBLIGATION AGREEMENT

I understand that all applicable copayments and deductibles are due at the time of services. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Neurosurgical Associates, P.C. for services rendered. I authorize representatives of Neurosurgical Associates/Columbia University Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. If my current policy prohibits direct payment to the doctor, I will forward the check and explanation of benefits to Neurological Associates.

Patient Signature: _____
Date: ____/___/____

Guarantor Signature: _____
Date: ____/___/____

I am aware that _____, M.D. does not participate with my Commercial Insurance and is an Out-of-Network Provider.

Patient Signature: _____
Date: ____/___/____

MYCOLUMBIADOCTORS PATIENT PORTAL SIGN UP

Access your personal records securely, 24/7, on a computer, smartphone, or iPad.

- ☐ YES, Send me an invitation to join myColumbiaDoctors. Email: _____
- ☐ **NO, do not** send me an invitation to join myColumbiaDoctors.

Look for an email invite from **noreply@followmyhealth.org** and click the registration link.

Patient's Preferred Language _____ ☐ I decline to respond.

Patient Signature: _____ Date: ____/____/____

_____, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

UNIT # _____

PATIENT INFORMATION

Date: ____/____/____
Patient Name:

_____
(Last Name)

_____ _____
(First Name) (Middle Initial)

Date of Birth: ____/____/____ Sex: □ M □ F

Address: _____
City: _____
State: _____ Zip: _____
Home #: (_____) _____-_____
Cell #: (_____) _____-_____
Email: _____

Father's First Name: _____
Mother's First Name: _____
Employer's Name: _____
Occupation: _____
Work #: (_____) _____-_____
Fax #: (_____) _____-_____

Spouse Name: _____
(Last Name)

_____
(First Name)
Date of Birth: ____/____/____

Cell #: (_____) _____-_____
Email: _____

If different than patient:
Guarantor's Name: _____
(Last Name)

_____
(First Name)
Date of Birth: ____/____/____ Sex: □ M □ F

Cell #: (_____) _____-_____

INSURANCE

Primary Insurance: _____
Policy #: _____
Group #: _____
Phone #: (_____) _____-_____

Secondary Insurance: _____
Policy #: _____
Group #: _____
Phone #: (_____) _____-_____

Check if apply and answer the following questions:
□ Workers Compensation
□ Auto Accident/NoFault
Date of Accident: ____/____/____
Carrier Name: _____
Representative Name: _____
State of Accident: _____
Policy #: _____
Address: _____
Phone #: (_____) _____-_____

REFERRING PHYSICIAN

Referring Physician Name:

_____
Address: _____
Phone #: (_____) _____-_____

Primary Care Physician Name:

_____
Address: _____
Phone #: (_____) _____-_____

Pharmacy Name: _____
Address: _____
Phone #: (_____) _____-_____

ColumbiaDoctors

Patient Request for Unencrypted Email Communication

Patient Name:_____ **Date of Birth:** _____

Phone Number:_____ **Email Address:**_____

This form authorizes your provider/program to communicate with you via unencrypted email.

I understand that communications over the Internet or use of an email system may not be secure and there is no assurance of confidentiality when communicating via unencrypted email.

Please be advised that:

- **This request applies only to the healthcare provider or program stated below. A separate form is required if you would like to request to communicate via unencrypted email with another health care provider or program.**
- An email address must be provided
- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided is accurate and I accept responsibility for messages sent to or from this email address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form.
- Communication over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email.
- Email communications may be forwarded to other providers and documented in my medical record for my treatment.
- I have the right at any time to revoke this authorization by contacting my provider and informing them that I wish to revoked my authorization.
- I agree to hold ColumbiaDoctors and individuals associated with ColumbiaDoctors harmless from any and all claims and liabilities arising from or related to this request to communicate via unencrypted email.

_____ _____

Signature of patient **Date**

_____

Name of Physician or Program

Updated July 2017

Columbia University
Medical Center

THE SPINE CENTER at
The Neurological Institute
710 West 168th Street, 5th Floor
New York, NY 10032
Telephone: (212) 305-9625 Fax: (212) 342-1540

We are looking forward to working with you!

For your first appointment, please:

- Arrive 15 minutes prior your appointment time
- For low back treatment: please bring you loose clothing and sneakers. example: (shorts, sweat pants, t-shirt)
- For neck treatment: please bring t-shirt or tank top

For your insurance coverage please bring:

- All of your insurance cards
- A physical therapy prescription that is filled out, dated and signed by your doctor every 3 months
- A filled-out physical therapy "pre-authorization form" with your primary care physician's signature and telephone number on it, if this is required by your insurance company

****Notice of Advise:**

- At the time of your Physical Therapy visit, if you do not have a referral from you physician or nurse practitioner your **treatment may not be covered** by your health plan. It is your *(patients)* responsibility to obtain all referrals if required by your health insurance policy up to date.

Policy for ALL your therapy appointments:

- We urge you to keep all of your scheduled therapy sessions and to be on time.

If you miss appointments:

- If you miss 2 or more appointments, your therapy sessions may be cancelled.

If you are late for an appointment:

- If you are 10 or more minutes late, you session may either be shortened or rescheduled. Please be on time for all appointments because other patients are scheduled after you.

If you need to cancel or change an appointment:

- If you must cancel or change you appointment, please call us at least 24 hours before your scheduled appointment at 212-305-9625. This will give us enough time to give your time slot to someone else.

I have read the physical therapy policies and understand them.

****Assignment of Benefits for Physical Therapy:** I hereby authorize assignment of payment directly to Neurosurgical Associate, PC at The Spine Center. If my current policy prohibits direct payment to the providers, I will forward a check to the above address. I understand that I am financially responsible for charges that are not covered by my insurance. I understand that if I do not have a referral from a physician, podiatrist, or nurse practitioner, there is a possibility that treatment may not be covered by my health care plan insurer and that my treatment by be a covered expense if rendered pursuant to such referral. *I am fully aware that I am fully responsible for fees denied or not covered by my insurance.*

_____ _____

Patient Signature/Guardian *Signature* Date

Thank you very much. We appreciate your cooperation.