



## New Patient Medical Therapy Paperwork

In order to help determine if you are a good candidate for regenerative/medical medicine treatments, please fill in the information below to the best of your ability.

Today's Date: \_\_\_\_\_

Legal Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Sex:  Female  Male

Race:  White  African American  Hispanic  Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\*Email(required): \_\_\_\_\_

***\*Email is used for secure patient portal communication, online scheduling, and electronic statements.***

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you give us permission to contact this person in the event of an emergency?  Yes  No

How did you hear about our office? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Present Complaints:

1. Main Problems: \_\_\_\_\_

\_\_\_\_\_

2. In spite of the fact that you are not a doctor, you are in fact the person that knows more about your condition than anyone else. In your own words and your own opinion, what do you think the real problem is? \_\_\_\_\_

\_\_\_\_\_

3. Symptoms:(List All) \_\_\_\_\_

\_\_\_\_\_

4. Severity of Problem(continued on next page):

Minimal (annoying but causing no limitation)

Slight (tolerable but causing a little limitation)

Moderate (sometimes tolerable but definitely causing limitation)

Severe (causing significant limitation)

Extreme (causing near constant limitation (>80% of the time))

5. What relieves your symptoms or causes them to return: \_\_\_\_\_

6. Describe the first time you remember having symptoms: \_\_\_\_\_

7. If your symptoms include pain:

What is the quality (Sharp, dull, stabbing, color, ect): \_\_\_\_\_

Does the pain radiate?  Yes  No If yes, where? \_\_\_\_\_

8. Do your symptoms occur at a specific time, place, or environment?  Yes  No If yes, when and for how long do symptoms last each episode? \_\_\_\_\_

9. What types of treatment have you received?

a. Prescription/drug therapy \_\_\_\_\_

b. Nutritional \_\_\_\_\_

c. Alternative/holistic \_\_\_\_\_

10. List your health goals in order of importance: \_\_\_\_\_

Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

11. What are you hoping happens today as a result of your consultation? \_\_\_\_\_

12. How often are you aware of your main problem (circle one):

Occasionally (25% of the time)

Frequently (75% of the time)

Intermittently (50% of the time)

Constantly (100% of the time)

13. If you cannot find a solution to your problem what do you think will happen? \_\_\_\_\_

14. Due to your condition have you lost time from (describe how much time and what tasks have been limited):

Work:  Yes  No Describe: \_\_\_\_\_

Family:  Yes  No Describe: \_\_\_\_\_

Leisure Activities:  Yes  No Describe: \_\_\_\_\_

Medications(List all prescription, over-the-counter, botanicals, homeopathic, and supplements)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical and Social History**

Surgeries/Hospitalization Dates: \_\_\_\_\_

Trauma Date: \_\_\_\_\_

Past/Recent Illness Date: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced Spouse: \_\_\_\_\_

Children/Ages: \_\_\_\_\_

Do you use:

Alcohol  Yes  No How many drinks and how often? \_\_\_\_\_

Tobacco  Yes  No How many and how often? \_\_\_\_\_

Caffeine  Yes  No How much and how often? \_\_\_\_\_

What is your area of greatest pain? \_\_\_\_\_

What other areas of your body give you pain? \_\_\_\_\_

Have you been given a diagnosis in the past?  Yes  No

If yes, what was it? \_\_\_\_\_

What made you want to do something about your pain today? \_\_\_\_\_

Please mark any and all of the following if you have or have had any:

- Cancer
- Kidney/Liver Disease
- Immune System Disease
- Bone/Joint Problems
- Platelet Dysfunction Syndrome
- Hypertension
- Autoimmune Diseases
- Osteoporosis
- Sleeping Disorders
- Metabolic Disease
- Gastrointestinal Disease
- Lung/Pulmonary Disease
- Consistent Use of NSAIDS
- Other: \_\_\_\_\_
- Acid Reflux Disease
- Hemodynamic Instability
- Ulcers
- Septicemia
- Heart Disease
- Critical thrombocytopenia

Which of the above bothers you the most? \_\_\_\_\_

\_\_\_\_\_

PRP, Stem Cell, Injections

What activities would you like to do if this were not a problem? \_\_\_\_\_

What have you tried to relieve/get rid of this problem?(Check all that apply)

- Medications
- Physical Therapy
- Chiropractic Care
- Injections
- Exercise
- Massage
- Nutrition
- Stretching
- Nothing
- Other: \_\_\_\_\_

Patient Name(Print): \_\_\_\_\_

Patient Signature(X): \_\_\_\_\_ Date: \_\_\_\_\_

**Consultation for Regenerative and Medical Services**

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for care. There will be a one-on-one consultation with the Doctor to:

- ❖ Review my case history to determine if the practice may be able to help me;
- ❖ Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, ect and discuss my problems and answer questions.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended prior to treatment. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

If applicable, I understand that PRP and Stem Cell therapies are not FDA approved although there are multiple studies shown that this treatment does work.

Patient Name(Print): \_\_\_\_\_

Patient Signature(X): \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge and agree to the **Patient Health Information Consent Form.\***

I acknowledge and agree to the **Missed Appointment Policy** including the **\$50** missed appointment fee.\*

*\*Policies are available on the clipboard for review.*

**Patient/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_