Regenerative Wellness Consultation

PERSONAL INFORMATION – To be filled out by patient

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email _____

Spouse 's Name_____ Phone Number_____

Your Occupation_____ Retired? Yes No

GENERAL SYMPTOMS Pease check ALL that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Arthritis in Hand
- ☐ Arthritis in Feet
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor wound healing
- ☐ Excessive thirst or urination

DENTAL HISTORY Please check ALL that apply

- ☐ Loose Teeth
- ☐ Root Canals
- ☐ Crooked Teeth
- ☐ Gum Recession
- ☐ Ailing Implants
- ☐ TMJ
- ☐ Bad Breath
- ☐ Amalgams- Silver/Mercury
- ☐ Extractions
- ☐ Missing Teeth

PRESENT HEALTH CONDITION

In order of importance, list the issues you are interested in correcting.

1._____

2._____

3._____

List approximately how long you have noticed these problems.

1._____

2._____

3._____

Is there a certain time of day any of these problems are better or worse?

_____

_____

Circle the things you have used for these problems:

RX Medications: _____

Aleve *Tylenol* *Ibuprofen* *Motrin*

Massage Therapy *Chiropractic* *Physical Therapy*

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Is your balance/walking ability affected?
If yes, please describe:

_____

What do you think is causing your problem?

_____

List the doctors you have seen for these problems, treatment you received:

_____

_____

_____

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Electric Shocks
☐ Fatigue	☐ Heavy Feeling	☐ Cold Hands/ Feet	☐ Reduced Mobility

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes daily? _____

Do you drink? ☐ Yes ☐ No If yes, how many drinks daily? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how much exercise daily? _____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Please give name and office phone number of your primary care physician.

Name_____Phone_____

When were you last seen there? _____

May we send them updates on your treatment/condition? ☐ Yes ☐ No

List ALL allergies/sensitivities to medication, food, and other items here: Reaction:

_____ _____

_____ _____

_____ _____

List the prescription drugs you are currently taking (or you may attach a list):

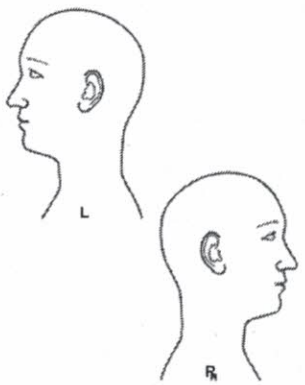
Name	Dose (mg or IU)	Times Daily

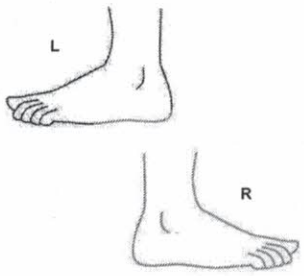
List all nutritional supplements (vitamins, herbs, homeopathies, etc.) :

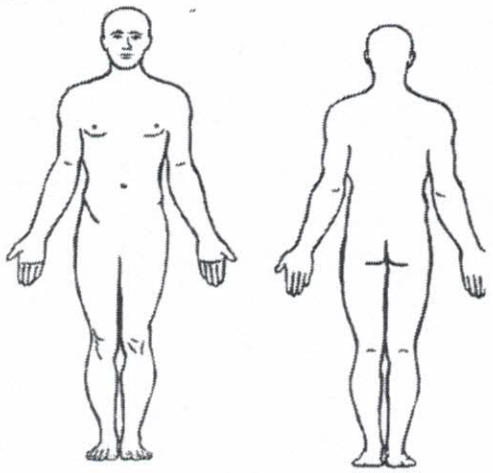
Name	Dose (mg or IU)	Times Daily

Please mark the area & type of pain on the drawings using the codes listed below.

N - Numbness T - Tingling S - Soreness P - Pain A - Ache ST - Stiffness







This is a confidential record of your medical history. The doctor reserves the right to discuss this information with medical professionals Copies of this record can only be released with your specific authorization.

Name_____Signature_____

(Patient)

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