Date: ______________________________

Stem Cell Evaluation
New Patient Information

Name: ____
Last First MI

Date of Birth: ______________ Sex: ❑ Male ❑ Female

Who may we thank for referring you to our office? ____

Email address: ____

Mailing Address: ____
Street/Apt City State Zip

Telephone: Cell_____________________Work__________________Alt.________________

May we leave you voicemails regarding your appointments? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _______

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

SIGNATURE (X)_____________________________________**DATE** ______________________

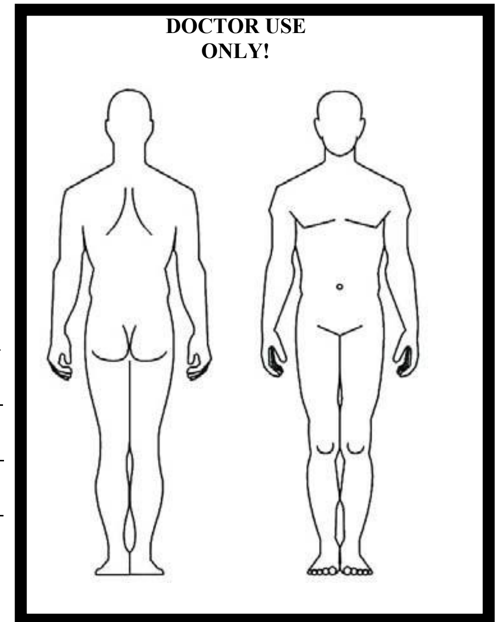
Belleview SPINE AND WELLNESS

Stem Cell Evaluation Patient Questionnaire

Name:______________________________DOB:_____/_____/__________Age:_______Date of Exam:_______________

Please check off any of the following where you experience pain:

❑Back ❑Hip
❑Shoulder ❑Ankle
❑Neck ❑Hand
❑Knee ❑Elbow
❑Feet ❑Wrist



Other *(Explain)*____

Which of the above is the worst? ____

How long have you had it? ____

What does it feel like? *(Describe)* ____

What have you done that has helped this problem?________________________________

What does this problem prevent you from doing?_________________________________

What have you tried to help relieve/get rid of this problem and how much did it help? (Circle)

❑Medications | Helped? ***Little*** ***Some*** ***Much***
❑Exercise | Helped? ***Little*** ***Some*** ***Much***
❑Nutrition | Helped? ***Little*** ***Some*** ***Much***
❑Phys. Therapy | Helped? ***Little*** ***Some*** ***Much***
❑Chiropractic | Helped? ***Little*** ***Some*** ***Much***

Does this cause:
❑Moodiness
❑Irritability
❑Sleep interruptions
❑Restriction of Daily Activities

How does this affect your work?
❑Decreased productivity
❑Unable to work long hours

How does this impact your life?
❑Lose patience with spouse/children
❑Difficulty with household duties

Current Pain Level 1-10 (10 being highest):_____/10 Please rate your overall quality of life? Scale of 1-10 (10 is best): _____/10
Please rate your ability to perform at work? Scale of 1-10(10 being peak performance): _____/10

Please list **all** current medications, including name, dosage, and frequency:
____
____
____

If you've ever had surgery, list procedure(s) and date(s):
____
____
____

Have you had significant past trauma? Y/N
If yes, please explain:
____
____
____

Social History:

Intake of following: **Caffeine_______**cups/day **Alcohol_______**drinks/week **Cigarettes_______**packs/day

Exercise frequency: ❑Never ❑Daily ❑Weekly ❑Walking ❑Running ❑Swimming ❑

Lifting *How would you rate your overall health?* ❑Excellent ❑Good ❑Fair ❑Poor

Please list any known **allergies**: ____

Do you have any of the following conditions: ___ ***Hepatitis B or C*** ___ ***HIV*** ____ ***Clotting or Blood Disorder*** ____ ***Lyme Disease***

Is there anything else you feel we should know? ____

Belleview
SPINE AND WELLNESS

Patient Name:____ **Date:**_________

Past Medical History and Review of Systems

Medicines previously tried, dosage, duration and outcome.

☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos

Please check ALL options you have previously tried to assist in above symptoms:

_____Over the counter medications
_____Prescriptions
_____Dietary Changes
_____Exercise
______ Consult with specialist
______ Supplements
______ Alternative medication/treatment therapies

Y	N	**Neurological**
____	____	Migraines
____	____	Headaches: how often?_______________
____	____	Slurring of speech
		Ear/Nose/Throat
____	____	Altered taste/smell
____	____	Night Blindness
____	____	Sore Throat
____	____	Gingivitis
____	____	Nose bleeds
		Endocrine
____	____	Diabetes
____	____	Thyroid problems
		Cardiovascular
____	____	High blood pressure
____	____	High cholesterol
____	____	Chest pain
____	____	Palpitations-racing heart beat
____	____	Swelling in hands/feet
____	____	Anemia
		Respiratory
____	____	Recurrent Respiratory Infections
____	____	Asthma
____	____	Chest Congestion
____	____	Wheezing
		GI
____	____	Stomach Pains or Cramping
____	____	Constipation
____	____	Reflux or Heartburn
____	____	Bloating/Gas
____	____	Nausea or Vomiting
		Musculoskeletal
____	____	Joint Pain
____	____	Arthritis
____	____	Chronic pain
____	____	Muscle Aches

Y	N	**Skin**
____	____	Eczema
____	____	Dermatitis
____	____	Excessive Sweating
____	____	Rashes
____	____	Brittle Nails
____	____	Hair Loss
____	____	Easy Bruising
____	____	Increased Bleeding
____	____	Numbness/tingling
		Genitourinary
____	____	Uterine fibroids
____	____	Ovarian cysts
____	____	Cancer (breast, ovarian, prostate, uterine)
____	____	Prostate problems
		Emotional/Mental
____	____	Depression
____	____	Anxiety
____	____	Mood Swings
____	____	Irritability
____	____	Memory Loss
____	____	Confusion
		Energy
____	____	Fatigue
____	____	Hyperactivity
____	____	Restlessness
____	____	Insomnia
____	____	Decreased Libido
____	____	Stress
		Weight
____	____	Decreased Appetite
____	____	Weight Gain
____	____	Inability to Lose Weight
____	____	Food Cravings
____	____	Binge Eating
____	____	Water Retention

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of_______________________________________.
(Please initial one of the following options and sign below.)

_____________ I wish to receive a paper copy of Privacy Notice.

_____________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

____ ____

Patient Name Printed Date

x____
Patient Signature

____ ____

Witness Name (Office Staff) Date

x____
Witness Signature