Regenexx® at INTERVENTIONAL ORTHOPEDICS OF RALEIGH

PATIENT INFORMATION

General Information

Patient Name: _____ Last four of SSN: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: _____ (circle) Cell Home Work

May we leave a message at above number? ☐ Yes ☐ No

Other phone: _____ (circle) Cell Home Work

May we leave a message at above number? ☐ Yes ☐ No

Email: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Information (if currently employed)

Employer Name: _____

Primary Care Physician (PCP) Information

PCP Name: _____

Address: _____

Phone: _____ Fax: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Primary: _____

Secondary: _____

REFERRAL

How did you find us? _____

May we use your name when thanking this person/business? ☐ Yes ☐ No

SERVICE AGREEMENT

Payment is due at the time services are rendered.

Signature:_____ Date:_____

Signature below is acknowledgement that you have received the Notice of our Privacy Practices.

☐ I accept ☐ I decline

Signature:_____ Date:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Telephone communication: ☐ Preferred phone
☐ Other phone

☐ Written communication: ☐ Okay to send US mail
☐ Okay to send email

☐ Okay to leave information with specified people (i.e. attorney, spouse, friend, Primary Care Physician).
Please include name, relationship and phone number:

_____

_____

_____

Patient Signature:_____ Date: _____

Print Name:_____

Date of Birth:_____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use, disclosure and requests for PHI to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

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NEW PATIENT HISTORY - MUSCULOSKELETAL

Name:_____ Age:____ DOB:_____ Hand dominance: ☐ Right ☐ Left

Chief complaint:_____ Date of injury/onset: _____

How did this problem occur?_____

_____

Other treatment(s) you have tried for this condition: ☐ Physical Therapy ☐ Chiropractic

☐ Injections ☐ Surgery ☐ Other _____

Imaging or other tests: ☐ X-ray ☐ MRI ☐ CT Scan ☐ EMG

Has surgery been recommended? ☐ Yes ☐ No

Use the symbols below to mark areas on the body where you feel that type of sensation:

KEY:

= = = numbness

^ ^ ^ ache

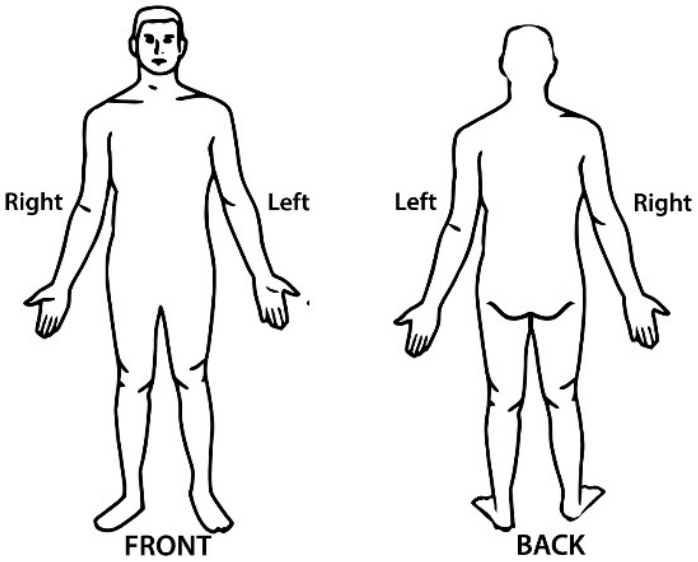
⊙⊙⊙ pins and needles

/ / / stabbing

X X X burning

- - - shooting

* * * tingling



Pain Rating Scale

Please make an "X" on the line below that corresponds to the area of your body where you feel pain and its severity. Rate your pain level on an average day by placing the "X" along the line from "NO PAIN" on the left to "WORST PAIN I CAN POSSIBLY IMAGINE" on the right.

	NO PAIN									WORST PAIN I CAN POSSIBLY IMAGINE
Back Pain	1	2	3	4	5	6	7	8	9	10
Leg Pain	1	2	3	4	5	6	7	8	9	10
Neck Pain	1	2	3	4	5	6	7	8	9	10
Arm Pain	1	2	3	4	5	6	7	8	9	10

When do you experience pain?_____

What makes your pain worse?_____

What makes your pain better?_____

What daily activities does this problem affect?_____

Review of Systems

Check symptoms or findings below that you have experienced recently:

Constitutional: ☐ weight change ☐ weakness ☐ fatigue ☐ fever ☐ nausea
Eyes: ☐ vision problems ☐ double vision
ENMT: ☐ hearing problems ☐ dizziness ☐ sinus trouble ☐ sore throat ☐ ringing ears
Cardiovascular: ☐ shortness of breath ☐ chest pain ☐ leg swelling ☐ increased blood pressure
Respiratory: ☐ cough ☐ coughing up blood ☐ wheezing ☐ asthma
Gastrointestinal: ☐ trouble swallowing ☐ heartburn ☐ vomiting ☐ diarrhea ☐ blood/black tar stools
Genitourinary: ☐ pain with urination ☐ blood in urine ☐ urgency ☐ incontinence
Musculoskeletal: ☐ joint pain/stiffness ☐ cramps ☐ weakness ☐ loss of motion
Skin: ☐ rash ☐ lumps ☐ itching ☐ dryness ☐ hair changes ☐ nail changes
Neurological: ☐ fainting ☐ blackouts ☐ seizures ☐ paralysis ☐ weakness ☐ numbness ☐ memory loss ☐ headaches
Psychological: ☐ nervousness ☐ tension ☐ mood changes ☐ depression ☐ anxiety
Endocrine: ☐ heat or cold intolerance ☐ sweating ☐ thirst ☐ changes with hunger
Hematology: ☐ bruising ☐ bleeding ☐ transfusion reactions
None of the above listed symptoms ☐

Past Medical History

Medical Illnesses Check all that apply: ☐ ***No medical illnesses***

☐ Anemia	☐ Deep vein thrombosis	☐ High blood pressure	☐ Seizures
☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Sleep disorders
☐ Bowel/bladder incontinence	☐ Gout	☐ Hyper/hypo thyroid	☐ Stroke
☐ Broken bones	☐ Heart attack	☐ Osteoarthritis	☐ Stomach ulcers
☐ Cancer	☐ Heart murmur	☐ Osteoporosis	
	☐ Hepatitis	☐ Rheumatoid arthritis	

☐ Other not listed above: _____

Injuries List injuries (include broken bones, concussions, motor vehicle accidents, falls, etc.): ☐ ***No injuries***

_____

_____

Surgeries List surgeries (include dates, if known): ☐ ***No surgeries*** _____

_____

_____

Allergies to medications/foods/chemicals: ☐ **No allergies** ☐ Yes - list _____

_____

Medications prescribed and over-the-counter medications (Advil, Motrin, etc.), vitamins and supplements:
☐ No medications ☐ Yes - list (include dosage and amount if known) _____

_____

_____

Family History Check those that apply: ☐ ***No family history of medical problems***

☐ Arthritis ☐ Back Problems ☐ Diabetes ☐ Cancer ☐ Heart Problems
☐ Other: _____

Social History

Smoking history: ☐ Never ☐ Former ☐ Current daily ☐ Current intermittent
Substance use/frequency: ☐ Alcohol (# per week) _____ ☐ Other (type & amount per week) _____
Do you exercise? ☐ Yes (type & amount per week) _____ ☐ No
Occupation: _____ Hobbies/Interests: _____