



Regenexx® at



INTERVENTIONAL  
ORTHOPEDICS  
OF RALEIGH

Dwayne Patterson, MD  
7101 Creedmoor Rd, #109  
Raleigh, NC 27613

919-355-9236 (appts M-F 9-5)  
919-324-1704 (office T,W,Th 9-4:30)  
919-516-0070 (fax)

### PATIENT INFORMATION

#### General Information

Patient Name: \_\_\_\_\_ Last four of SSN: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ 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: \_\_\_\_\_

May we send email to this address?  Yes  No

Marital Status:  Single  Married  Partnered  Separated  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.

Messages may be left by phone or email as indicated on p1.     Yes     No

Okay to receive US Mail to address listed on p1.     Yes     No

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.



**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 \_\_\_\_\_

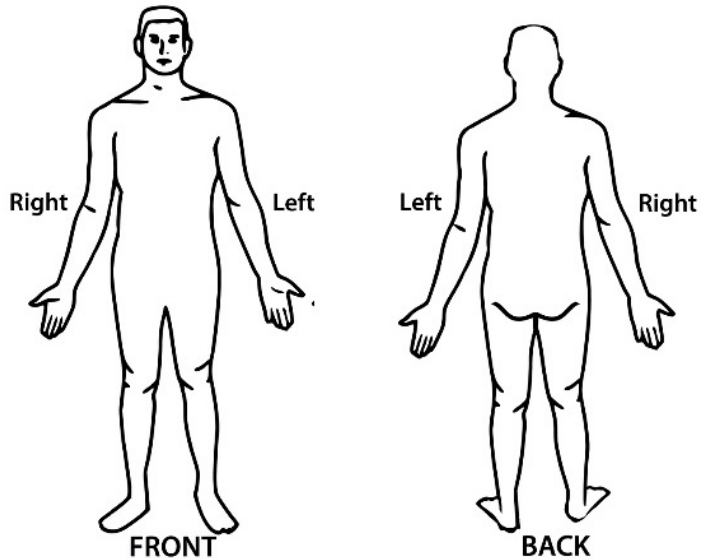
Imaging or other tests:  X-ray  MRI  CT Scan  EMG

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

**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

**Allergy:**  wheezing  itching  hives

**None of the above listed symptoms**

## Past Medical History

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Bowel/bladder incontinence    | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Hyper/hypo thyroid   | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Broken bones                  | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Stomach ulcers  |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Osteoporosis         |  |
| <input type="checkbox"/> Other not listed above: _____ | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Rheumatoid arthritis |  |

**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, oral and topical medications, vitamins and supplements:

**No medications**  Yes - list any meds taken in last 8 weeks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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) \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies/Interests: \_\_\_\_\_

Physical activity/exercise: (type & amount per week) \_\_\_\_\_