Heritage Regenerative Medicine -Physical Medicine Treatment Intake
(Please Print Clearly)

Full Name:	SS #:	Date:

DOB:	Age:	Sex: M F	Marital Status: M S D W	# of Children:

Email Address:
Address:

City:	State:	Zip:

Home Phone #:	Cell #:

Occupation (Current or Previous):	Retired: Y N

Primary Insurance:	Secondary Insurance:

Spouse's Name:

Emergency Contact Name:	Phone #:

Tell Us About Your Past Health:

Y	N	← Lower Back Pain	Y	N	← Diabetes (A1C= ______)	Y	N	← High Cholesterol
Y	N	← Leg/Foot – Pain/Numbness	Y	N	← Hand Problems	Y	N	← Shingles
Y	N	← Prior Spinal Surgeries	Y	N	← Neuropathy	Y	N	← Cancer/Chemotherapy
Y	N	← Spinal Fractures	Y	N	← Heart Attack	Y	N	← Kidney Problems or Dialysis
Y	N	← Spinal Stenosis	Y	N	← Heart Problems	Y	N	← Gout
Y	N	← Spinal Arthritis	Y	N	← High/Low Blood Pressure	Y	N	← Knee/Hip/Foot Surgery
Y	N	← Sciatica	Y	N	← Vascular Leg Problems	Y	N	← Leg Fractures
Y	N	← Neck Pain	Y	N	← Vascular Surgery _____	Y	N	← Joint Replacement
Y	N	← Herniated Disc	Y	N	← Stroke	Y	N	← Plantar Fasciitis

List Any Medications and/or Vitamin Supplements You're Currently Taking or Attach Medication List:

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

List Below Any **SERIOUS** Medical Conditions You Have Had:
Name of Your Primary Care Physician (PCP):
May We Contact Them with Updates Regarding Your Treatment: Y N
List Below Any **NECK**, **BACK**, **ARM**, **HAND**, **LEG**, or **FOOT SURGERIES** You've Had?

Have You Had a Nerve Conduction Study/EMG? □ No	□ Yes - When:
Do You Exercise Regularly? □ No	□ Yes - What:

Are Your Symptoms Worse at Night? □ No	□ Yes – Around What Time:
Describe Below What Kind of Problem(s) Are You Having:	

On A Scale, How Would You Rate Your Symptoms (10 is the worst)?

0 - No pain at (feeling perfectly normal)
1- Mild pain (e.g. mosquito bite or itch)
2 - Discomforting (pinching the skin between thumb and 1st finger)
3 – Tolerable (noticeable, e.g. accidental cut or an injection needle)
4 – Distressing (strong, deep pain like a toothache or bee sting)
5 – More distressing (strong/deep/piercing, e.g. standing on a sprained ankle or mild back pain. Normal lifestyle is curtailed because of it)
6 – Intense (strong/deep/piercing, e.g. bad headache + bee sting, or bad back pain)
7- Very intense (like 6, put pain completely dominates your senses; you can't think clearly ½ the time)
8 – Utterly horrible (can't think clearly at all; e.g. childbirth w/o medication or bad migraine)
9 – Excruciating/unbearable (you demand surgery or pain killers, no matter the risk)
10 – Unimaginable/unspeakable (so bad you will go unconscious, e.g. hand/foot crushed by heavy weight. Most people never experience this).

How Long Ago Did It Start:
What Makes It Better:
What Makes It Worse:

How Would You Describe Your Symptoms (Circle Below Any That Apply):

Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

What Do **YOU THINK** Is Causing Your Problem?

Is This Condition Interfering with Any of the Following (Circle Below Any That Apply):

Work	Sleep	Daily Routine	Chores	Walking	Standing	Shopping

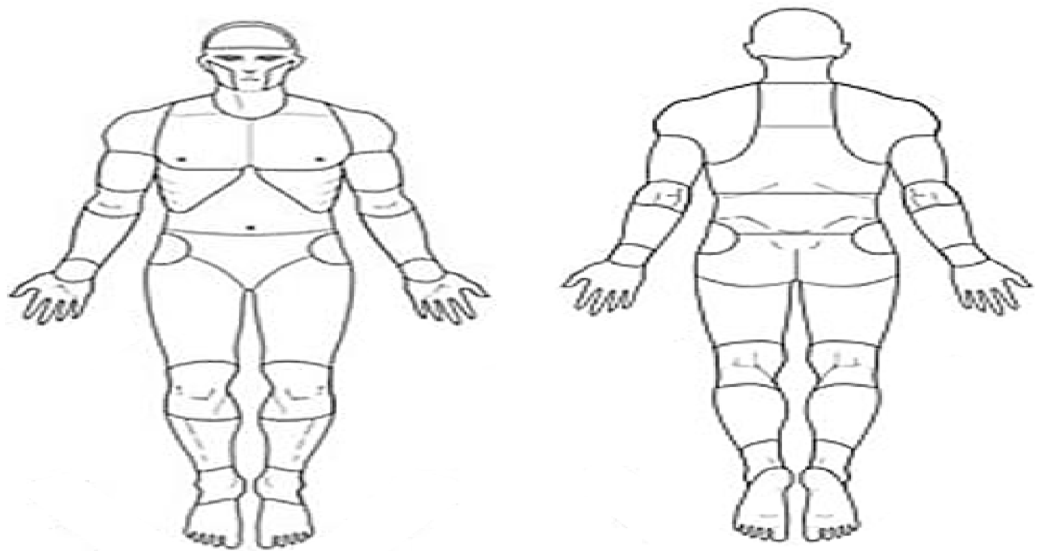
Has Anybody Else in Your Family Had Same or Similar Condition: □ No	□ Yes – Who:

How Would You Rate Your Average Pain Over the Past Week For This Problem?
No Pain **Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10

Indicate What You Consider to Be an Acceptable Level of Pain After Completion of the Treatment, If You Have to Accept Some Pain?
No Pain **Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10

Indicate On These Drawings The Body Area(s) Where You Are Currently Experiencing Symptoms:

Use The Following Key:
Pain = P
Numbness = N
Tingling = T
Stiffness = S



Do You Have Any Of The Following:		
Pacemaker: Y N	**Defibrillator**: Y N	**Spinal Stimulator**: Y N

Are You Taking Any **Blood Thinners** Not Including Aspirin? □ No	□ Yes – Which One:
List Below Any Surgical Devices in Your Body (for example - screws, pins, rods, plates, etc.)	
List Any **Medication OR other Allergies** (food, latex, etc.) Below:	
Do You Smoke? □ No	□ Yes – For How Long and How Much:
Do You Drink Alcohol? □ No	□ Yes – What and How Much per week:

Focused Review of Systems – Circle Below Any of the Following You've Experienced in The Past Year:

Neck Pain	Back Pain	Knee Pain	Dizziness	Unexpected Weight Loss	Blurred Vision
Difficulty Swallowing	Chest Pain	Shortness of Breath	Constipation	Painful Urination	Anxiety Depression

Tell Us How This Is Affecting You:

What Are Your Symptoms Like at Their WORST:	
Is Your Balance or Walking Ability starting to be affected? □ No	□ Yes – Describe Below in What Ways:

Which of the Following is **True** for Your Condition (Check One of the Below):		
□ It's getting better on its own	□ It's staying the same	□ It's getting worse as time goes by
List Any Daytime Activities (You **Used to be able to do** when you were feeling better) that are now limited:		

List The Three Main "Health Goals" That You Would Like to Accomplish:
1.
2.
3.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical history.

Signature: ____ Date: _____________________

How Did You Hear About Our Office?
☐ **TV** ☐ **Radio** ☐ **Newspaper** ☐ **Seminar** ☐ **Other:** ____________________
☐ **Doctor Referral (Name of Doctor:** ____________________________________**)**

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