OrthoRegen®

Non-Surgical, Regenerative Medicine Treatment for Musculoskeletal Conditions

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Name: _____ Date of Birth: / /

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST THE DOCTORS IN DEVELOPING AN INDIVIDUALIZED PLAN OF CARE FOR YOU. THIS INFORMATION IS CONFIDENTIAL.

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR CONDITION:

_____
_____
_____
_____
_____
_____
_____

Medical/Surgical History: *(e.g. diabetes, heart disease, osteoarthritis, high blood pressure, asthma etc)*

_____
_____
_____
_____
_____

Current Medications:

_____
_____
_____

Allergies:

_____

HOW LONG HAVE YOU SUFFERED FROM THIS PROBLEM? _____

PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

PLEASE CIRCLE: IMPROVING PAIN WORSENING PAIN

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

0 1 2 3 4 5 6 7 8 9 10
(no pain) *(severe pain)*

IS YOUR PAIN CONSTANT OR INTERMITTENT? *(circle one)*

HOW WOULD YOU DESCRIBE THE PAIN? *eg sharp dull achy electric* _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT HELPS ALLEVIATE YOUR PAIN? _____

DOES THE PAIN RADIATE TO ANY OTHER PART OF YOUR BODY? _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION? *(Please tick all that apply)*

_____ No other treatment _____ Massage therapy ____ Chiropractor
_____ Physical therapy _____ Acupuncture ____ Other:
_____ Epidural Spinal Injection _____ Surgery
_____ Medications (Please list) _____

HAVE YOU HAD ANY OF THE FOLLOWING EXAMS RECENTLY? *(CIRCLE ALL THAT APPLY)*

MRI X-RAY CT SCAN EMG/NCS (Nerve test) ULTRASOUND

OCCUPATION: _____

HOBBIES: _____

Height_____ **Weight**_____

MARITAL STATUS (CIRCLE ONE):

Single De facto Married Separated Divorced Widowed

DO YOU CONSUME ALCOHOLIC BEVERAGES? *(CIRCLE ONE)* YES NO HOW OFTEN:_____

DO YOU SMOKE CIGARETTES? YES NO CEASED – IF SO WHEN DID YOU QUIT? _____

FEMALE PATIENTS - ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? YES NO N/A

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

	YES	**NO**		**YES**	**NO**
General weakness			Abnormal bowel movements		
Leg Cramping			Frequent urination		
Numbness			Unable to urinate		
Shortness of breath			High blood pressure		
Swelling of hands, feet or ankles			Chest pain or angina		
Weakness of muscles or joints			Stroke		
Any difficulty walking			Heart surgery		
Pain in calves or buttocks			Heart disease		
History of falls or poor balance			Kidney disease		
Decreased sensation in arms or legs			Epilepsy/Seizures		
Psychiatric care			Lung disease		
Depression			Fevers		
Alcohol/Drug dependency			Emphysema/Bronchitis		
Hepatitis			Gout		
Weight Loss			Arthritis		
Thyroid problems			Diabetes		
Dizziness/Fainting			Irritable Bowel Syndrome		
Cancer			Stomach Ulcer		

Please sign below to confirm that the information presented in this questionnaire is accurate:

Signature: _____

Patient Name: _____ Date: _____