New Patient Intake Form

Patient Data

Patient Name: _____ Today's Date: _____
Address: _____ City: _____ State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email address:_____
Sex (Circle): M / F Date of Birth: _____ Age: _____ SSN: _____
Marital Status (Circle): Single / Married / Widowed / Separated / Divorced Number of Children: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ Spouse's Occupation/Employer: _____
Emergency Contact: _____ Phone: _____
How did you hear about us? _____ Name of person who referred you: _____

Reasons for Visit

	Primary Complaint Points	Which Side?		Primary Complaint Points	Which Side?
1.		L / R / Both	5.		L / R / Both
2.		L / R / Both	6.		L / R / Both
3.		L / R / Both	7.		L / R / Both
4.		L / R / Both	8.		L / R / Both

Check all that apply to the right of your selection:

Describe your pain…	✓	What makes your pain feel BETTER:	✓	How long does your pain last?	✓
Unspecified		Resting		Only when I move	
Aching		Shower		Only when active	
Acute		Medication		Only when standing up	
Burning		Heat		Only when I lie down	
Constant		Ice		Only sitting still	
Cramping		Stretching		On and Off	
Crushing		Chiropractic		Steady	
Dull		Exercise		Only morning	
Electrical		Massage		Only mid-day	
Radiating		Sitting		Only evening	
Sharp		Standing		All day	
Stabbing		Other:		Other:	

On a scale of 1 to 10, how bad is your pain? (One is none to ten is hospitalization): _____

Check all that apply to the right of your selection:

When is your pain most noticeable?				When did this pain start?		Do you have any other symptoms associated with this pain?	
Abrupt		When I walk		1-day ago		Numbness	
After Meal		When I exercise		1-week ago		Tingling	
At rest		Morning		1-month ago		Weakness	
Woken up		Mid-Day		6-months ago		Headaches	
Continuous		Evening		1-year ago		Change in Vision	
Episodic		At night		18-months ago		Dizziness	
Intermittent		Gradual		2-3 years ago		Loss of Bowel Control	
Other, Explain:				4-7 years ago		Loss of Bladder Control	
				8-10 years ago		Sexual Dysfunction	
				> than 10 years ago		Other:	

Have you seen any other provider in regards to your current? Check all that apply.							
No		Massage Therapist		Orthopedist		Primary Care Physician	
Chiropractor		Neurologist		Physical Therapist		Emergency Department	
Other:							

Medical Information

Primary Care Physician (PCP): _____ PCP Phone Number: _____

PCP Practice Name: _____

PCP Practice Address: _____

List all allergies: _____

_____

_____

Past Medical History

Check all that apply to the right of your selection:							
AIDS/HIV		Congestive Heart Failure		Immunosuppressive Therapy		Heart Attack	
Angina		Diabetes I / II		Osteoporosis		Stroke / TIA	
Arthritis		Rheumatoid Arthritis		Psychiatric Disorders		Thyroid Disease	
COPD		High Blood Pressure		Pulmonary Embolism		Tuberculosis	
Other:							

Medication

Please include any supplements and/or vitamins you take. If you already have a medication list, we can make a copy of it instead.

Medication Name	Dosage	Frequency

Social History

Check all that apply:		
<u>Alcohol:</u> ☐ 3-5/day or more ☐ 1-2/day ☐ 3-5/week or more ☐ 1-2/week ☐ 3-5/month or more ☐ 1-2/month ☐ 3-5/year or more ☐ 1-2/year ☐ Social drinking ☐ Never ☐ Last drink: _____ ☐ Recovering from alcohol abuse/history of alcoholism	<u>Cigarette Smoking:</u> ☐ 1-2 packs/day or more ☐ 3-5 cigarettes/day or more ☐ 1-2 cigarettes/day ☐ 1 pack/week ☐ 3-5 cigarettes/week ☐ 1-2 cigarettes/week ☐ 1 pack/month ☐ <1 pack/month ☐ Social smoking ☐ Never ☐ Last smoked: _____ ☐ History of smoking/ recovering smoker	<u>E-cigs/Vaping:</u> ☐ Currently vaping utilizing: _____mL ☐ Vaping with nicotine ☐ Vaping with CBD ☐ Social vaping ☐ Never ☐ Last used: _____ ☐ History of vaping/smoking/ recovering <u>Illicit Drug Use:</u> ☐ Current illegal drug user ☐ Never ☐ History of illegal drug use

Surgical History

If you already have a surgical history list, we can make a copy of it instead.

	Surgery	Year		Surgery	Year
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Renew
STEM CELL CLINIC

Family History

Check all that apply to the right of your selection under the appropriate category:				
Diagnosis	Father's Medical History	Mother's Medical History	Sibling's Medical History:	Children's Medical History
ADD / ADHD				
Alcoholism				
Alzheimer's				
Anemia				
Arthritis				
Asthma				
Bleeding Disorders				
Cancer				
COPD				
Coronary Artery Disease				
Diabetes I / II				
Epilepsy				
High Blood Pressure				
High Cholesterol				
Mental Illnesses				
Migraines				
Multiple Sclerosis				
Obesity				
Osteoporosis				
Parkinson's				
Sickle Cell Anemia				
Stroke				
Tuberculosis				

I verify that all content I have provided is accurate to the best of my knowledge. By signing below, I confirm that I have fully read over and filled out the above health history questionnaire as truthfully and accurately. I will now certify that I am under the care of another physician for all other medical conditions. I will consult this physician for any other medical services. I have completely and accurately disclosed any medical conditions and treatments, including prescription and non-prescription medications and supplements. By signing below, I provide consent for treatment by Dr. Lori Lynch, MD and any designated assistants.

Patient Name: _____

Patient Signature: _____Date: _____

If the patient is unable to complete the paperwork themselves for any reason, please provide the patient's representative's information:

Representative Name: _____Relationship to Patient: _____

Representative Signature: _____ Date: _____

HIPAA Patient Authorization Form

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. *You have the right to review our Notice before signing this Authorization and you are advised to do so*. This authorization for release of information covers the period of healthcare from:

_____, 20_____, to _____, 20_____(7-year time frame).

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

- The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.
- The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.
- All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.
- The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.
- The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.
- The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.
- The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by: _____

Printed Name – Patient or Representative

_____

Signature **Date**

_____

Relationship to Patient (if other than patient)

Witness: _____

Printed Name – Clinic Representative

_____

Signature **Date**

For Internal Use:

_____ Patient Refused to Sign _____ Patient Unable to Sign for the Following Reason: _____