Submitted

Patient Application

Name:

*First Middle *Last

DOB:

*Month *DD *YYYY Age *E-mail

Height:

Gender Feet Inches Weight

How did you hear about us?

Address:

*Number/Street *City

*State/Province *Zip Code *Country

Phone:

*Best Phone Number Alternate Phone Fax

Insurance Information

Health Insurance? Insurance Company

Subscriber ID#: Group ID# (if any)

Emergency Contact Information

*First Name *Last Name *Relationship *Phone

Number/Street City

State/Province Zip Code Country

Primary Diagnosis Information

Diagnosis Date: ________ ________

*Chief Complaint *Month *YYYY

*Current Symptoms

*Treatment History

*Have you had an MRI in the past 12 months? ☐ *Have you had an X-Ray in the past 12 months? ☐

Medications Information

*Are you taking anticoagulants like Plavix or Coumadin? [ ]

*Have you had any steroid injections like cortisone over the past 3 months? [ ]

If yes, what kind of shots and when did you receive them? ______________________

*Have you ever had any kind of stem cell therapy? [ ]

If yes, list when, where and what type of stem cells you received.

Social History

*Do you smoke cigarettes? [ ] *Cigars? [ ] *Pipe? [ ]

If yes, how much per day? ______________________

*Do you drink beer? [ ] *Wine? [ ] *Liquor? [ ]

If yes, how much per day? ______________________

Prior Surgeries

*Please list any prior surgeries and their dates (mm/yyyy). Use "none" if you haven't had surgery in the past.

*Do you have any metal plates or rods inside your body?

If yes, list details including type and location:

Cancer

*Have you ever been diagnosed with any type of cancer, especially bone marrow cancer?

If yes, please list type of cancer, month and date of diagnosis and current status:

If you've had a recent mammogram, list the date (mm/yyyy) and result ____________________

If you've had a recent PSA test, list the date (mm/yyyy) and result ____________________

Diabetes

*Are you diabetic? If yes, are you taking insulin?

Neurological

*Vision worsening? *Black spots in field of vision?

*Uncontrollable eye movements? *Muscle weakness? *Muscle wasting?

Neurological

*Difficulty walking? *Decreased hand strength? *Fainting?

*Speech problems? *Involuntary muscle twitching? *Depression?

*Stiff or rigid muscles that affect walking, movement or speech? *Dizziness?

*Overactive or over responsive reflexes? *Underactive or under responsive reflexes?

*Memory loss? *Sleep disturbances?

Pulmonary

*Do you have asthma? *Chronic bronchitis? *Chronic cough?

*Emphysema? *Tuberculosis?

Cardiovascular

*Do you have problems with blood circulation? ☐ *Leg cramps? ☐

*Tired feeling in legs? ☐ *Swollen ankles? ☐ *Varicose Veins? ☐

*Tingling sensation in arms and legs? ☐ *Tingling sensation in hands and legs? ☐

*Do you have any ulcers or open wounds on your body? ☐

*Hypertension or high blood pressure? ☐ *Do you have heart failure? ☐

*Do you have coronary artery disease? ☐ *Have you had a heart attack? ☐

*Have you had a stroke or transient ischemic attack (TIA)? ☐

Gastrointestinal

*Do you suffer from acid indigestion? ☐ *Do you suffer from bloating? ☐

*Ulcers? ☐

If yes, list type(s) and date(s) diagnosed:

☐

*Recent loss of appetite? ☐ *Recent rapid weight gain? ☐ *Recent rapid weight loss? ☐

*Have you had upper GI endoscopy? ☐ If yes, when (mm/yyyy)? ______

*Do you have hepatitis A? ☐ *B? ☐ *C? ☐ *Gall bladder problems? ☐

*Unusual yellow skin color (jaundice)? ☐ *Recurring Diarrhea? ☐

Upper Respiratory

*Chronic Sinusitis? ☐ *Allergic sinus problems? ☐ *Chronic allergic rhinitis? ☐

*Sinus headaches? ☐ *Chronic colds? ☐

Rheumatic Screen

*Do you have rheumatoid arthritis? ☐ *Soft Tissue Rheumatism? ☐ *Joint pain? ☐

*Back pain? ☐ Other rheumatic conditions? ______

Endocrinological

*Overactive Thyroid? [ ] *Underactive Thyroid? [ ] *Adrenal gland dysfunction? [ ]

*Have you started menopause? [ ]

Other endocrinological conditions? ______________________________

Other Illnesses or Conditions

*Please list any other illnesses or conditions you have. If you don't have any, enter "None".

[ ]

Family History

*Low blood sugar? [ ] *Diabetes? [ ] *Thyroid problem? [ ]

*Hormone problem? [ ] *Cancer? [ ] *High blood pressure? [ ]

*Kidney problem? [ ] *Leukemia? [ ] *Arthritis? [ ] *Prostate problem? [ ]

*Mental disorder? [ ] *Anxiety? [ ] *Lung problem? [ ] *Heart problem? [ ]

*Stroke? [ ] *Fatigue? [ ]