NEW YOU
Regenerative Medicine

# Confidential Patient Information

Personal Information Today's Date

| | | | |
|---|---|---|---|
| Last Name: | First: | Middle: | Date of birth: |
| Address: Street | City | State | Zip |
| Home phone: | | Work phone: | |
| Cell phone: | | Email address: | |
| What type of Health Insurance do you have: | | | |
| Marital status: M S W D | | Health Insurance ID Number: | |
| ○ Male ○ Female | | | |
| No. of children: | | Are you Pregnant? Yes ☐ No ☐ | |
| Occupation: | | | |
| Employer's name & address: | | | |
| Spouse/guardian name: | | | |
| Spouse's Occupation/Employer: | | | |
| Name of person responsible for account: | | | |
| Referred to this Office by: ○ Friend/Family Member –Who may we thank? What is their name? | | | |
| ○ Newspaper ○ Post Card ○ Sign ○ Flyer ○ TV ○ Radio ○ Google ○ Facebook | | | |

# Consultation/Examination Terms

1. I understand that today's consultation is used to determine whether or not I am a candidate for care.

2. I understand that the consultation process does not establish me as a patient under New You Regenerative Medicine's care and there is no doctor-patient relationship or obligation.

3. I am aware that after the consultation, I may not be accepted as a patient. I understand that New You Regenerative Medicine is not able to and does not accept every case. New You Regenerative Medicine's schedule is busy and we strictly limit the number of new patients we accept so as to ensure a high quality of care.

4. Please fill out all paperwork completely to the best of your knowledge. **Do not leave anything blank.** Also remember to fill out the accompanying Medical Intake. If paperwork is not filled out completely we may need to reschedule. We want to make certain we use our consultation time as efficiently as possible.

5. I have read, understand and accept the terms of the consultation/examination. Initial ____

Main Complaints:

1)_____ 2)_____
3)_____ 4)_____

How long have you suffered with this problem?

_____

Would you like improvement with any of the following?:

- ☐ Knee Function
- ☐ Shoulder Function
- ☐ Neck/Mid Back Function
- ☐ Low Back Function
- ☐ Lose Weight

How have you tried to take care of this problem in the past?

- ☐ Medications. If yes please specify. _____
- ☐ Routine medical
- ☐ Exercise
- ☐ Nutrition/Vitamins
- ☐ Chiropractic Care/Physical Therapy
- ☐ Injections. If yes, please specify what type. _____
- ☐ Surgery If yes please specify. _____

How did the previous methods work for you?

_____
_____

How does this problem interfere with the following areas in your life?

Work:_____
Family:_____
Hobbies:_____
Life:_____

Do you know how this problem may have started?

_____

_____

_____

Are you here visiting us to:

- ☐ Resolve my immediate problem
- ☐ Lifestyle program for optimized living
- ☐ Both

Other:_____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific

_____

_____

_____

_____

_____

_____

How would you describe your family support?

- ☐ My Spouse fully supports my decisions
- ☐ My spouse needs more information to be supportive
- ☐ I am single, but I do have a support system with friends/family
- ☐ I am single and do not have a support system

Rate on a scale of 1-10: 1 is the least and 10 is the most.

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would be compliant with instructions that would be given to help you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

*"If you are going to be alive... You might as well live!"*

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LIST ANY ALLERGIES YOU HAVE:

DO YOU HAVE A SULFA ALLERGY: (CIRCLE ONE) Y N

LIST ANY MEDICATIONS YOU ARE TAKING(PLEASE INCLUDE NAME, DOSE AND HOW MUCH PER DAY):

DO YOU CURRENTLY USE OR CONSUME: TOBACCO OR TOBACCO PRODUCTS: Y N HOW MUCH: _____

ALCOHOL: Y N HOW MUCH AND HOW OFTEN: _____

RECREATIONAL DRUGS: Y N

LIST ANY PAST SURGERIES YOU HAVE HAD AND THE YEAR YOU HAD THEM:

WHAT DO YOU DO FOR EXERCISE? HOW OFTEN? HOW LONG?:

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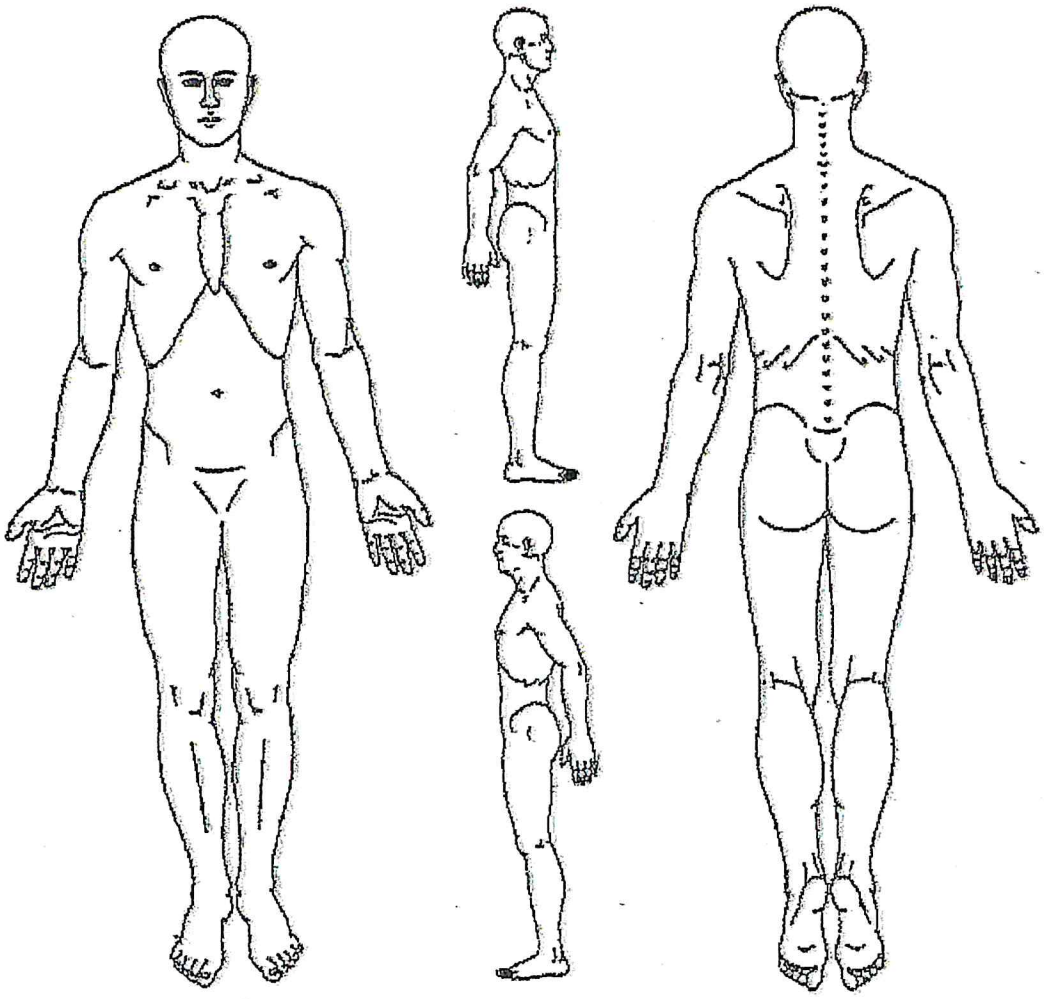
PAIN DIAGRAM On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE B – BURNING N – NUMBNESS P – PINS & NEEDLES S – STABBING O – OTHER



SEVERITY OF PAIN: (CIRCLE ONE) MILD MODERATE SEVERE

FREQUENCY OF PAIN: (CIRCLE ONE) CONTINUOUS COMES AND GOES

PAIN QUALITY: (CIRCLE ALL THAT APPLY) ACHING DULL SHARP BURNING CRAMPING NUMBING

SPASMING: ELECTRIC SHOCK TINGLING PINS AND NEEDLES

PAIN INTENSITY (0- NO PAIN TO 10- EXCRICIATING PAIN): AT BEST ___/10 AT WORST ___/10

NOW ___/10

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DOES YOUR PAIN RADIATE: (CIRCLE ONE) Y N IF YES DESCRIBE WHERE:

_____

_____

DO YOU HAVE WEAKNESS: (CIRCLE ONE) Y N IF YES DESCRIBE WHERE:

_____

_____

DO YOU HAVE TINGLING OR NUMBNESS: (CIRCLE ONE) Y N IF YES DESCRIBE WHERE:

_____

_____

ARE YOU HAVING DIFFICULTY WALKING: (CIRCLE ONE) Y N IF YES DESCRIBE HOW:

_____

_____

## FAMILY HISTORY

PLEASE CIRCLE Y OR N AND RESPOND TO THE QUESTION: DO **YOU** CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE MEDICAL DIAGNOSIS LISTED BELOW? PLEASE INCLUDE ANY OF YOUR FAMILY MEMBERS THAT HAVE BEEN DIAGNOSED AS WELL.

CANCER Y N WHO? _____

HEART DISEASE Y N WHO? _____

STROKE Y N WHO? _____

HYPERTENSION Y N WHO? _____

ARTHRITIS Y N WHO? _____

AUTO IMMUNE DISEASE Y N WHO? _____

THYROID DISEASE Y N WHO? _____

OVER WEIGHT Y N WHO? _____

FIBROMYALGIA Y N WHO? _____

HIGH CHOLESTEROL Y N WHO?_____

DISABILITY Y N WHO?_____

PROBLEM SIMILAR TO YOURS Y N WHO?_____

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT YOU MAY BE EXPERIENCING NOW:

**GENERAL SYMPTOMS:** FEVER WEIGHT LOSS WEIGHT GAIN EXTREME FATIGUE

**EYES:** DOUBLE VISION BLURRY VISION INTOLERANCE TO BRIGHT LIGHT

**EARS:** HEARING LOSS RINGING IN EARS EAR DISCHARGE

**NOSE:** BLEEDING DISCHARGE CONGESTION POSTNASAL DRIP

**MOUTH:** DENTAL PROBLEMS BLEEDING GUMS TMJ PAIN

**CARDIOVASCULAR:** CHEST PAIN IRREGULAR HEARTBEAT PALPITATIONS

**RESPIRATORY:** COUGH WHEEZING SHORTNESS OF BREATH TROUBLE TAKING DEEP BREATH

**GASTROINTESTINAL:** NAUSEA VOMITING ABDOMINAL PAIN CONSTIPATION DIARRHEA BLOOD IN STOOLS LOSS OF APPETITIE HEARTBURN GASTRIC REFLUX

**MUSCULOSKELETAL:** JOINT PAIN MUSCLE PAIN

**SKIN:** RASH ITCHING ABNORMAL SWEATING UNUSAUL MARKS

**GENITOURINARY:** IRREGULAR PERIODS VAGINAL BLEEDING AFTER MENOPAUSE FREQUENT OR PAINFUL URINATION BLOOD IN URINE IMPOTENCE PAIN WHILE HAVING SEX

**NEUROLOGICAL:** HEADACHE TINGLING OR NUMBNESS FORGETFULLNESS DIFFICULTY SLEEPING

**PSYCHIATRIC:** DEPRESSION ANXIETY LACK OF MOTIVATION SUICIDAL THOUGHTS

**ENDOCRINE:** COLD OR HEAT INTOLERANCE EXCESSIVE THIRST EXCESSIVE URINATION OR APPETITE HAIR LOSS VERY DRY SKIN LEG/FEET SWELLING HIV/AIDS

**HEMATOLOGICAL:** UNUSUAL BRUISING OR BLEEDING ENLARGED LYMH NODES EDEMA/SWELLING


# Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health
Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call you, email, or send test to you to confirm appointments? Yes No

May We leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member for your family? Yes No

If yes, please name the member allowed to received information:_____

Patient Name

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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# FINANCIAL POLICY

NAME:_____

You the patient are responsible for your medical bills. If you are covered by an insurance which Back in Line Chiropractic Center bills, we will submit the forms for you and bill you for any remaining balance. If you have an insurance that we do not bill, we will give you a form which you can submit yourself. Not all insurances cover office visits and currently no regenerative medicine treatment is covered by any insurance. If you elect to proceed with a regenerative medicine procedure, you will be required to pay the agreed upon price on the day of the procedure/procedures.

Co-pays and dispensary purchases are due at the time of service.

Patient Name

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date