Southern Stem Cell Institute

First Visit Questionnaire

1. Where do you experience pain and discomfort?

2. If in multiple areas, what area is your main concern right now?

3. Will you be bringing a friend or loved one who can help you make decisions in regard to your care? Our providers are prepared to perform treatment on the same day as your consultation so that you can embark on your journey of healing as soon as possible. **O Yes O No**

4. Have you or a loved one visited our website and viewed our webinar? **O Yes O No**

5. Even though our regenerative medicine services aren't covered by insurance, we have treatments that can fit every budget. Are you interested in learning more about our financing solutions? **O Yes O No**

6. Can you endure continue living in the condition you are in right now? **O Yes O No**

7. How did you hear about Southern Stem Cell Institute?

8. Did you know we have a state-of-the-art office - one of the best in the world? We are proud to use products from Signature Biologics, Dr. Neil Riordan's company. He is the foremost expert In stem cell research and treatment, with over 70 published research papers and 40 patents. We are also proud to offer patients a new hyperbaric chamber, pulsed electromagnetic field therapy, shock wave therapy, Georgia's only Prism Light Pod, and much more to expedite relief. **O Yes O No**

(Please Print Clearly)

PATIENT INFORMATION						
Last name:	First:	MI:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Preferred Nickname:	Email address:			Birth date:	Age:	Sex:
Street address:		Social Security no.:		Primary phone no.:		
City:		State:		ZIP Code:		
Occupation:	Employer:			Employer City:		
How did you hear about our office?						
Did you attend a seminar? If so, which one?						

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no.:	Work/Cell phone no.:

Patient/Guardian Signature _____ Date _____

Patient Name: Date: 3

Allergies:	
□ Penicillin Allergy	Reaction: □ Anaphylaxis □ Other:
□ No Known Drug Allergy	□ Yes (Drug / Reaction):
□ No Known Food Allergy	□ Yes:
□ No Known Environmental Allergy	□ Yes:

Implanted Devices		
Pacemaker / Defibrillator □ Yes □ No	Spinal Stimulator □ Yes □ No	Other:

Medications / Supplements			
Name	Dosage	How many times a day?	Reason

Past Medical Health History (check if applicable)					
□	Blood Thinners: □ Current □ Past	□	Blood clots: □ Limbs □ Lungs	□	Vitamin deficiency: □ B12 □ D3
□	Anesthesia Problems	□	Heart Disease	□	Hernia
□	Anemia	□	High Cholesterol	□	Hepatitis
□	Depression	□	High Blood Pressure	□	Sciatica: R L Both
□	Anxiety	□	Chest Pain	□	Gout
□	Arthritis	□	Lung Disease	□	Stroke/ TIA
□	Sleep Apnea	□	COPD	□	Chest pain
□	Epilepsy	□	Emphysema	□	Lupus
□	Fibromyalgia	□	Thyroid Problems	□	Lower Back Pain
□	Polio	□	HIV	□	Spinal Fractures
□	Neuropathy	□	Kidney Disease	□	Disc: □ Herniation
□	Diabetes Type 1	□	Liver Disease		□ Bulge
□	Diabetes Type 2	□	GERD	□	Spinal stenosis
□	Ulcers	□	MRSA	□	Degenerative Disc
□	Spider/Varicose Veins	□	Shingles	□	Fusion:
□	Plantar Fasciitis	□	Chemical Exposure: □ Pesticides □ Agent Orange		
□	CANCER: Location: _____ YEAR: _____ Chemotherapy □ Y □ N Radiation □ Y □ N Declared in Remission □ Y □ N □ Y □ N Medication Type:_____				
Other:					

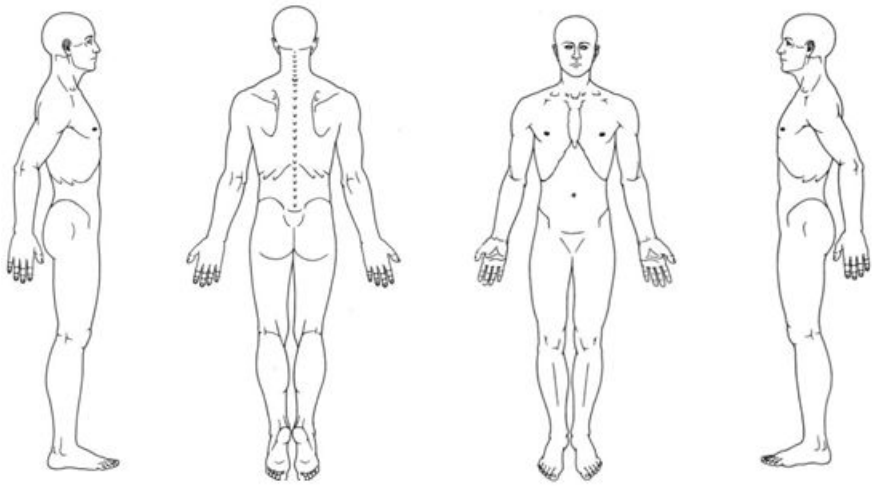
Past Surgical History			
Surgery	***Date***	***Surgery***	***Date***
Laminectomy: Specific Level			
Spinal Fusion: Specific Level			
Joint Replacement:			

Social History					
Tobacco	□ Pack per day:		□ Occasional	□ Never	□ Quit: year
Chewing Tobacco	□ Daily	□ Weekly	□ Occasional	□ Never	□ Quit: year
Alcohol	□ Daily	□ Weekly	□ Occasional	□ Never	□ Quit: year
Marijuana/THC	□ Daily	□ Weekly	□ Occasional	□ Never	□ Quit: year
Recreational Drugs	□ Daily	□ Weekly	□ Occasional	□ Never	□ Quit: year
Exercise	□ Daily	□ Weekly	□ Occasional	□ Never	□ Quit: year
Notes:					

Family History
Mother: □ Living □ Deceased: Cause of Death: Relevant Health History:
Father: □ Living □ Deceased: Cause of Death: Relevant Health History:
Notes:

What brings you in to the clinic today (chief complaint)?

Area of Pain/Numbness/Injury: Please Circle area of concern.



History of Present Illness	
Does the pain radiate or travel? □Yes □ No	If so, where to?

Pain and Numbness on Average Day

(0 no pain or numbness, 10 being the worst pain/worst numbness).

Pain Scale	0	1	2	3	4	5	6	7	8	9	10
Numbness	0	1	2	3	4	5	6	7	8	9	10

When did the pain and or numbness begin?	Was there a specific incident?

What makes the pain/numbness better? □ Walking □ Standing □ Sitting □ Lying down □ Pain medicines
Other (specify):

What makes the pain/numbness worse? □ Rest □ Walking □ Standing □ Sitting
Other (specify):

Is the pain: □ Constant □ Intermittent □ Worse at night

Other Symptoms (check if applicable)			
□	Joint Redness	□	Numbness/Tingling: Location:
□	Joint Swelling	□	Throbbing:
□	Joint Tenderness	□	Aching:
□	Joint Warmth	□	Burning:
□	Limping	□	Stabbing:
□	Locking of the Joint	□	Shooting:
□	Loss of Range of Motion: Joint	□	Pins/Needles:
□	Inflexibility	□	Pulsating:
□	Balance Issues	□	Deadness:
□	Difficulty Standing	□	Dull:
□	Difficulty sitting to standing	□	Stinging:
□	Difficulty climbing stairs	□	Cramps:
□	Difficulty laying down	□	Stiffness:
Other Symptoms not mentioned:		□	Spasms:
		□	Cold:

Diagnostics
Have you had an X-ray, CT, MRI, or other imaging? If yes, when: Results:
Have you considered surgery? □ Yes □ No
Have you had previous treatments or surgeries for this issue? □ Yes □ No If so, which procedure(s)?
Have you had any Nerve testing, EMG? □ Yes, when _____ □ No Results:

Patient Name: Date: 6

Review of Systems
(check if you are <u>currently</u> experiencing any of these)

General
□ Weight loss or gain
□ Fatigue
□ Weakness
□ Trouble sleeping

Skin
□ Texture/tone
□ Chronic skin conditions
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair/nail changes
□ Ease of bruising

Head/Neck
□ Headaches
□ Neck pain
□ Swollen Glands
□ Stiffness

Nose
□Stuffiness
□ Discharge
□ Itching
□ Hay fever/seasonal
□ Nosebleeds
□ Sinus Pain

Musculoskeletal
□ Muscle, back or other joint pain
□ Stiffness
□ Difficulty moving/walking
□ Redness of joints
□ Swelling of joints

Endocrine
□ Heat or cold intolerance
□ Sweating
□ Frequent Urination
□ Thirst
□ Change in appetite

Eyes/Ears
□ Vision Changes
□ Pain
□ Redness
□ Blurry/double vision
□ Flashing lights/ Speck
□ Glaucoma
□ Cataracts
□ Hearing changes

Throat
□ Bleeding
□ Sore Tongue
□ Dry Mouth
□ Hoarseness
□ Thrush
□ Non-healing sores

Breasts
□ Lumps
□ Pain
□ Discharge

Respiratory
□ Cough
□ Sputum
□ Coughing up Blood
□ Shortness of Breath
□ Wheezing
□ Painful Breathing

Vascular
□ Leg Swelling
□ Calf Pain with Walking
□ Leg Cramping
□ Vein Issues
□ Restless Leg Syndrome

Psychiatric
□ Nervousness
□ Stress
□ Depression
□ Motivation
□ Memory Loss
□ Other Mood Changes

Cardiovascular
□ Chest pain
□ Tightness
□ Palpitations
□ Shortness of Breath
□ Difficulty Breathing
□ Swelling
□ Other Discomfort

Gastrointestinal
□ Difficulty Swallowing
□ Heartburn
□ Change in Appetite
□ Nausea
□ Rectal Bleeding
□ Constipation
□ Diarrhea
□ Yellow eyes/skin

Genitourinary
□ Urinary Frequency
□ Urinary Urgency
□ Burning / Pain
□ Blood in urine
□ Incontinence
□ Loss of urinary strength
□ Libido/sexual desire
□ Erectile Dysfunction

Neurologic
□ Concentration
□ “Brain Fog”
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor
□ Burning / Pain

OFFICE USE ONLY:

Provider: Date: