Patient Information

Patient Name ____ Phone Number ______________

Date of Birth ______________ ◯ Male ◯ Female Height _______ Weight _______

Address ____ City ____________ State _________

Zip Code _________ Email Address ___________________________________

Emergency Contact Information

Name ______________________________________ Emergency Contact Phone ______________

HIPAA Waiver of Authorization in case of emergency? ◯ Yes ◯ No

Name ______________________________________ Emergency Contact Phone ______________

HIPAA Waiver of Authorization in case of emergency? ◯ Yes ◯ No

Physician Information

Physician Name ______________________________________ Contact Phone ______________

Date of Last Physical ___________

Specialist Name ______________________________________ Contact Phone ______________

Pharmacy Information

Pharmacy Name ______________________________________ Contact Phone ______________

Address ____ City ____________ State _________

Zip Code _________

Insurance Information

Primary Insurance _________________________________ Policy Number _________________

Insured Name __________________ Insurance Type ◯ Medical ◯ Prescription

Secondary Insurance _________________________________ Policy Number _________________

Insured Name __________________ Insurance Type ◯ Medical ◯ Prescription

Social History

◯ Single ◯ Married ◯ Long-term relationship ◯ Divorced/Separated

Years married/in long term relationship ______ Times Married ______ Times Divorced ______

Are you in a monogamous relationship? ◯ Yes ◯ No

If No, how many active partners do you currently have? ______

Do you use condoms? ◯ Yes ◯ No

Do you have sex with ◯ Women ◯ Men ◯ Both

Education ◯ High School ◯ Some College ◯ Completed College

Are you currently employed? ◯ Yes ◯ No

What type of work do you do? ____

Do you have an advanced directive/living will? ◯ Yes ◯ No

Do you exercise? ◯ Yes ◯ No How Often? ___________________

Do you drink caffeine? ◯ Yes ◯ No

Do you eat/drink ◯ meat ◯ chicken ◯ fish ◯ milk ◯ cheese ◯ sugar ◯ gluten

◯ fried foods ◯ processed foods ◯ vegetarian ◯ vegan

Do you smoke ◯ cigarettes ◯ cigars? ◯ No

If Yes, how many per day? _________ At what age did you start? _________

If you have quit, when did you quit? _________

Do you chew tobacco or dip? ◯ Yes ◯ No

Do you drink Alcohol? ◯ Yes ◯ No

If yes, how often do you drink? ◯ Rarely ◯ Social ◯ Daily

What do you drink? ◯ Beer ◯ Wine ◯ Liquor

How much do you drink per day? ◯ 1-3 drinks ◯ 4-6 drinks ◯ 7+ drinks

Do you use recreational drugs? ◯ Yes ◯ No

If yes, please list ____

How often do you use recreational drugs? ◯ On Occasion ◯ Routinely

Do you use any drugs **NOT** prescribed by your doctor? ◯ Yes ◯ No

If yes, please list ____

Current or Past Medical Conditions (check all that apply)

◯ ADHD ◯ Congestive Heart Failure ◯ Gout ◯ Lung Disease ◯ Spider / Varicose Veins
◯ Anemia ◯ Cholesterol Problems ◯ Head Trauma ◯ Lupus ◯ Spinal Fractures
◯ Anxiety ◯ Chronic Pain ◯ Headaches ◯ Menstrual Issues ◯ Spinal Fusions
◯ Arthritis ◯ COPD / Emphysema ◯ Heart Attack ◯ Neuropathy ◯ Spinal Stenosis
◯ Asthma ◯ Degenerative Disc ◯ Heart Disease ◯ Nutritional Issues ◯ Stroke / TIA
◯ Autoimmune ◯ Depression ◯ Hepatitis ◯ Osteoporosis ◯ Thyroid Problems
◯ Bipolar Disorder ◯ Diabetes ◯ Hernia ◯ Plantar Fasciitis ◯ Ulcers
◯ Blood Clots ◯ Disc Herniation / Bulging ◯ HIV/AIDS ◯ Prostate Issues ◯ Vascular Disease
◯ Blood Pressure ◯ Epilepsy ◯ Kidney Disease ◯ Sciatica ◯ Vitamin Deficiencies
◯ Cancer ◯ Fibromyalgia ◯ Liver Disease ◯ Shingles ◯ OTHER
◯ Chest Pain ◯ GERD ◯ Lower Back Pain ◯ Sleep Apnea

Other or Specify Above

____

____

Please list all current ***PRESCRIPTION OR OVER THE COUNTER*** medications you are currently using, dosage, and how often you are taking them.

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

Please list all current herbal medicines, supplements, etc., dosage, and how often you are taking them

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

Please list any allergies you have

____

Surgical History – Please check all surgeries you have had

◯ Appendectomy ◯ Cholecystectomy ◯ Pacemaker ◯ Defibrillator ◯ Stent (heart/aorta)
◯ Hysterectomy ◯ Mastectomy ◯ Hernia ◯ Neck ◯ Back
◯ CABG (heart bypass) ◯ Other

Please Specify

____

____

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Family Medical History

Illness	Father	Mother	Siblings	Children
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Hyperlipidemia				
Thyroid Issues				
Autoimmune				
Dementia				
Other				

____

____

Health Maintenance History – Please list dates you last had any of these tests performed

EGD (upper endoscopy) ___________

Colonoscopy ___________

Heart Cath ___________

Heart Stress Test ___________

Dental Checkup ___________

Bone Density/DXEA ___________

Pneumonia Vaccine ___________

Tetanus Vaccine ___________

Shingle Vaccine ___________

HPV Vaccine ___________

Women Only

Pap Smear ___________

Mammogram ___________

Men Only

PSA (prostate bloodwork) ___________

Diabetics Only

Eye Exam ___________

Foot Exam ___________

Smokers Only

Pulmonary Function Test ___________

Chest X-Ray ___________

Chest CT ___________

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Please Check Any Symptoms That You Are Currently Experiencing:

General
- ◯ Weight Loss or Gain
- ◯ Fatigue
- ◯ Weakness
- ◯ Trouble Sleeping

Skin
- ◯ Texture/Tone
- ◯ Chronic Skin Conditions
- ◯ Lumps
- ◯ Itching
- ◯ Dryness
- ◯ Color Changes
- ◯ Hair/Nail Changes
- ◯ Easily Bruised

Head/Neck
- ◯ Headaches
- ◯ Neck Pain
- ◯ Swollen Glands
- ◯ Stiffness

Nose
- ◯ Stuffiness
- ◯ Discharge
- ◯ Itching
- ◯ Hay Fever/Seasonal
- ◯ Nosebleeds
- ◯ Sinus Pain

Musculoskeletal
- ◯ Muscle, Back, or 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/Specks
- ◯ 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
- ◯ Difficulty Concentrating
- ◯ "Brain Fog"
- ◯ Dizziness
- ◯ Fainting
- ◯ Seizures
- ◯ Weakness
- ◯ Numbness
- ◯ Tingling
- ◯ Tremor
- ◯ Burning/Pain

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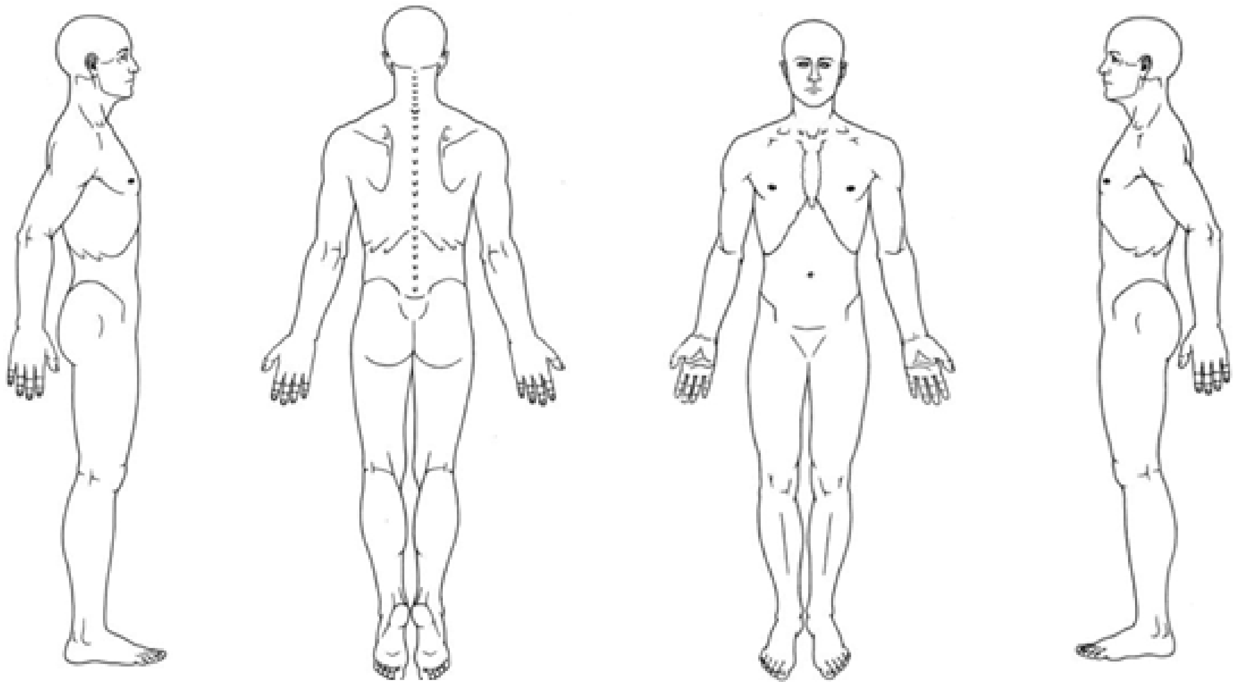
Current Weight _______ Goal Weight _______

What are your goals that you would like us to help with?

1. ____
2. ____
3. ____
4. ____

Are you currently experiencing any pain or numbness on a daily basis? Please circle any areas of concern.



Does the pain radiate or travel throughout the body? ◯ Yes ◯ No

Please Explain ____

When did the pain or numbness begin? ____

Was there a specific incident? ◯ Yes ◯ No Explain ____

What makes the pain/numbness better? ◯ Rest ◯ Sitting ◯ Standing ◯ Walking ◯ Other

Please explain ____

What makes the pain/numbness worse? ◯ Rest ◯ Sitting ◯ Standing ◯ Walking ◯ Other

Please explain ____

Is the pain: ◯ Constant ◯ Intermittent ◯ Worse at Night ◯ Other

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Pain and Numbness on Average Day

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

Pain Scale

Area 1 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 2 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 3 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 4 : ________________	0	1	2	3	4	5	6	7	8	9	10

Numbness Scale

Area 1 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 2 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 3 : ________________	0	1	2	3	4	5	6	7	8	9	10
Area 4 : ________________	0	1	2	3	4	5	6	7	8	9	10

Are you experiencing any of the following symptoms relating to the areas that are in pain and/or numb?

- ◯ Aching
- ◯ Burning
- ◯ Cold
- ◯ Cramps
- ◯ Deadness
- ◯ Difficulty Climbing Stairs
- ◯ Difficulty Laying Down
- ◯ Difficulty Standing Up
- ◯ Dullness
- ◯ Inflexibility
- ◯ Joint Redness
- ◯ Joint Swelling
- ◯ Joint Tenderness
- ◯ Joint Warmth
- ◯ Limping
- ◯ Locking of Joint
- ◯ Loss of Range of Motion
- ◯ Numbness
- ◯ Pins and Needles
- ◯ Pulsations
- ◯ Shooting Pain
- ◯ Spasms
- ◯ Stabbing Pain
- ◯ Stiffness
- ◯ Stinging
- ◯ Tinging
- ◯ Other

Have you had an X-Ray, CT, MRI, or any other imaging? If yes, when: ◯ Yes ◯ No When? _________

What was the result of the imaging? ____

Have you had any previous treatments or surgeries for this issue? ◯ Yes ◯ No

If so, which procedures? ____

Have you ever considered surgery? ◯ Yes ◯ No

Have you had any nerve testing, EMG? If yes, when: ◯ Yes ◯ No When? _________

What was the result of the testing? ____

New Patient Questionnaire

1. What is the reason you became interested in our clinic?
____
____
____
____

2. What goals would you like us to help you accomplish? (Example: Lose Weight, Be Pain Free, Etc.)
____
____
____
____

3. If you do have pain, where does it hurt? Please describe the type of pain, when it occurs, etc. Please be as specific as possible.
____
____
____
____

4. Can you continue living in the condition you are right now? ◯ Yes ◯ No

5. Will you be bringing in a friend or loved one who can help you make decisions in regards to your care? Our providers are prepared to treat you on the same day as your consultation so that you can embark on your wellness journey as soon as possible. ◯ Yes ◯ No

6. Even though our regenerative medicine services are not covered by insurance, we have treatments that can fit every budget. Are you interested in learning about our financing solutions? ◯ Yes ◯ No

7. How did you hear about REGENCare? ____

8. Have you or a loved one visited our website and viewed our webinar? If YES, what did you think?
◯ Yes ◯ No ____

REGENCare is a State-of-the-Art Office, and one of the biggest in the world. We are proud to use products from Signature Biologics which is Dr. Neil Riordan’s company. He is the foremost expert in Stem Cell Research and Treatments, with over 70 published research papers and 40 patents. We are also proud to offer patients treatments using our Hyperbaric Oxygen Chambers, Pulsed Electromagnetic Field Therapy (PEMF), Shockwave Therapy, Georgia’s only Prism Light Pod, and much more to take you on your Wellness Journey.

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