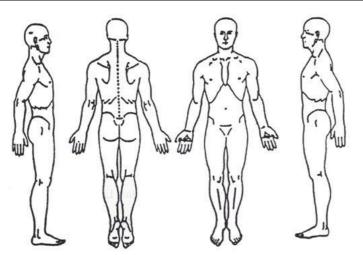


Patient History

First Name		Las	t Nan	ne				Date		
Date of Birth	_ Age	_ Socia	l Seci	ırity N	umber			Sex:	Male	Female
Home Phone	Work/Co	ell Phone	e		Ema	ail				
Address				_ City				_State	Zip _	
Referred by:										
Emergency Contact										
Name				_ Rela	tion to	Patient				
Primary Phone				_ Alte	rnate Pl	none				
Name				_ Rela	tion to	Patient				
Primary Phone				_ Alte	rnate Pl	none				
Briefly describe the charact Chief area/areas of complaint	:									
Onset: When did you first not	ce this?									
Provocative: What makes it we Palliative: What makes it bette	or?									
Quality: (Dull, sharp, ache, she	ooting, bur	ning, nun	nb, ho	t, cold)						
Radiation: Does it spread anyv	where?	υ,	,	, ,						
Severity: How much does it a	ffect your	life?								
Timing: What percentage of yo	our day do	you expe	erience	this?_						
Please rate your level of pai	<u>n:</u> 1 MII	2 LD	3	4	5 MODI	6 ERATE	7	8	9 SEV	10 ERE
Please mark the areas on vo	aur hody y	whore vo	u fool	nain u	sing the	followi	na ma	arlzare.		



Ache >>>>>>>>
Numbness
Pins and Needles 000000000000000000000000000000000000
Burning xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Center for Regenerative Medicine at Walnut Creek

1850 Tice Valley Boulevard | Walnut Creek, CA 94595 Phone: 925.310.7836 | Fax: 925.884.8474

Procedure	Date Perfor	<u>med</u>	Did Tl	nis H	elp?
□ Epidural Injections			Yes	/	No
☐ Facet Injections (Medial Branch Block)			Yes	/	No
☐ Trigger Point Injections			Yes	/	No
☐ Joint Injections			Yes	/	No
☐ Stem Cells			Yes	/	No
☐ Prolotherapy			Yes	/	No
☐ Nerve Ablation			Yes	/	No
☐ Other:			Yes	/	No
medications, vitamins, supplements, & herbs). Medication	<u>Dose</u>	Tablets Per Day	Prescribed	l by (Doctor)
				· · · · · · · · · · · · · · · · · · ·	
Do you take blood thinners? (e.g. Omega-3, baby as	pirin, fish oil, V	Vitamin E, flax se	ed oil) Yo	es i	/ No
<u>Pharmacy</u>	DI		Г		
Name					
Address	City		State Z	L1p _	
Allergy/Intolerance: Do you have any allergies to	medications?	Yes / No			
Please list drugs and reactions:					
Do you have allergies to: 🗖 Sulfa 🗖 Shellfish 🛴	TIV Contract I	Type Diletov D	1 Adhagira	(Pan	4- V : 4)

Patient (Last) _____ (First) _____ Date ____

^{*}Please note: In the event you are medically determined not a candidate for tissue allograft injections containing stem cells, you will be eligible for a full refund of the price paid for the consultation.

Past Medical History: Heart Attack	Asthma	Prostate Problem	Arthritis
Heart Disease	Diabetes	Stomach Ulcer	
			Pregnancy (x)
Angina (Chest Pain)	Cancer	Intestinal Problems	C-Sections (x)
Stroke	Tuberculosis	Seizures	Others:
High Blood Pressure	Lung Problems	Kidney Problems	
Depression	Liver Problems	Bleeding Problems	Previous Injury Date:
Anxiety	Thyroid Problems	Sleeping Difficulties	Body Part Affected:
Please list any other re	levant medical history		
<u>Procedure</u>		<u>Date</u>	Physician
			DI.
Company			Phone
Company		City	State Zip
Company		City	
CompanyAddress Occupation		City	State Zip
Company Address Occupation Social History		City # Hours po	StateZip er week currently working _
Company Address Occupation Social History Married Single	☐ Significant Other	City # Hours po	StateZip er week currently working _ w Number of Children
Address Decupation Social History Married	☐ Significant Other / No History of sme	City# Hours po	State Zip er week currently working _ w Number of Children Year quit smoking
Address Decupation Social History Married	☐ Significant Other / No History of smo	City# Hours po	StateZip er week currently working _ w Number of Children Year quit smoking How many?
Address Decupation Social History Married	☐ Significant Other / No History of smo	City# Hours po	State Zip er week currently working _ w Number of Children Year quit smoking
CompanyAddress Decupation Social History Married	☐ Significant Other / No History of small of the History of the Hist	City# Hours po	StateZip er week currently working _ w Number of Children Year quit smoking How many?
Company Address Decupation Social History Married Single Do you smoke? Yes Do you use alcohol? Do you have a history of Eamily History: Please	☐ Significant Other / No History of small street / No If yes, how for alcohol or drug abuse?	City# Hours pool Divorced Widowoking in the past: Yearsw often?	StateZip er week currently working _ w Number of Children Year quit smoking How many?
Address	☐ Significant Other / No History of smale of the History of smale of the History of smale of the History of th	City# Hours pool Divorced Widowsking in the past: Yearsw often?	State Zip er week currently working _ w Number of Children Year quit smoking How many? arthritis, cancer, heart disease, etc.
Address	☐ Significant Other / No History of small street / No If yes, how for alcohol or drug abuse?	City# Hours pool Divorced	StateZip er week currently working _ w Number of Children Year quit smoking How many?

Patient (Last) _____ (First) _____ Date ____

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