Center for Regenerative Medicine at Walnut Creek

Patient History

First Name ________________________ Last Name ________________________ Date ___________

Date of Birth _____________ Age ___ Social Security Number ______________ Sex: Male Female

Home Phone ____________ Work/Cell Phone ____________ Email ____________________________

Address ____________________________________ City __________________ State ___ Zip _____

Referred by: ____

Emergency Contact

Name ______________________________________ Relation to Patient ________________________

Primary Phone _______________________________ Alternate Phone __________________________

Name ______________________________________ Relation to Patient ________________________

Primary Phone _______________________________ Alternate Phone __________________________

Briefly describe the characteristics of your pain and symptoms

Chief area/areas of complaint: ____

Onset: When did you first notice this? ____

Provocative: What makes it worse? ____

Palliative: What makes it better? ____

Quality: (Dull, sharp, ache, shooting, burning, numb, hot, cold) ___________________________________

Radiation: Does it spread anywhere? ____

Severity: How much does it affect your life? ____

Timing: What percentage of your day do you experience this? ____________________________________

Please rate your level of pain: 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE

Please mark the areas on your body where you feel pain using the following markers:

Ache
>>>>>>>>>>>>>

Numbness
===============

Pins and Needles
00000000000000

Burning
xxxxxxxxxxxxxxxx

Center for Regenerative Medicine at Walnut Creek
1850 Tice Valley Boulevard | Walnut Creek, CA 94595
Phone: 925.310.7836 | Fax: 925.884.8474

Patient (Last) ___________________ (First) _________________ Date ____________

What treatments have you had?

Procedure	Date Performed	Did This Help?
❑ 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: Please list ALL medications you are currently taking (including over the counter medications, vitamins, supplements, & herbs).

Medication	Dose	Tablets Per Day	Prescribed by (Doctor)

Do you take blood thinners? (e.g. Omega-3, baby aspirin, fish oil, Vitamin E, flax seed oil) Yes / No

Pharmacy

Name ____ Phone ______________ Fax ______________

Address ____________________________________ City __________________ State ___ Zip _____

Allergy/Intolerance: **Do you have any allergies to medications?** Yes / No

Please list drugs and reactions: ____

____

____

Do you have allergies to: ❑ Sulfa ❑ Shellfish ❑ IV Contrast Dye ❑ Latex ❑ Adhesive (Band-Aid)

Do you have any allergies to food, insect stings, or other allergies? ________________________________

**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.*

Patient (Last) ___________________ (First) _________________ Date ____________

Past Medical History: Circle all conditions that you have or have had in the past.

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 relevant medical history: ____

____

Surgical History: Please list ALL surgical/medical procedure history beginning with the most recent.

Procedure	Date	Physician

Employment Information

Company ____ Phone _________________

Address ____________________________________ City _________________ State ___ Zip _____

Occupation ____________________________________ # Hours per week currently working ____

Social History

❑ Married ❑ Single ❑ Significant Other ❑ Divorced ❑ Widow Number of Children ______

Do you smoke? Yes / No History of smoking in the past: Years ____Year quit smoking_________

Do you use alcohol? Yes / No If yes, how often? ______________________ How many?______

Do you have a history of alcohol or drug abuse? ____

Family History: Please list known conditions. (e.g. joint/back problems, arthritis, cancer, heart disease, etc.)

Father	_______________________	Paternal Grandfather	_______________________
Mother	_______________________	Paternal Grandmother	_______________________
Children	_______________________	Maternal Grandfather	_______________________
Siblings	_______________________	Maternal Grandmother	_______________________

Are you interested in financing or monthly payment plans? Yes / No

**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.*