Patient Intake & Research Questionnaire

Info@stemcells.world | 909-695-1004 | Instagram @stemcellsports

Patient Information

Full Name:	Age:
Sex: [ ] Male [ ] Female	Weight:
Parent/Guardian Name:	Date of Birth:
Relationship to Patient:	Address:
Phone:	Email:
Emergency Contact:	Phone:
Primary Language:	Referred By:
Blood Type:	

Military Information

Have you ever served in the United States Armed Forces? [ ] Yes [ ] No

If yes:

Branch:

[ ]Army. [ ] Marines. [ ] Space Force. [ ] National Guard

[ ]Navy [ ] Air Force [ ] National Guard [ ] Reserves

Rank at Discharge:

Years of Service: From ______ To ______. Discharge Status: [ ] Honorable [ ] General [ ] Other:

Combat Deployments: [ ] Yes [ ] No

If yes, list locations and dates:

Service-Connected Injuries (List All) email: records@stemcells.world

Injury 1:

Date of injury:

How it occurred:

Injury 2:

Date of injury:

How it occurred:

Injury 3:

Date of injury:

How it occurred:

Post-Release Injuries or Conditions Developed After Service:

Currently receiving VA benefits? [ ] Yes [ ] No. VA Disability Rating: %

If yes, for what conditions:

Currently receiving care at a VA facility? [ ] Yes [ ] No

VA facility name:

Diagnosed With Any of the Following Related To Service:

[ ]Traumatic Brain Injury (TBI).	[ ] Gulf War Illness	[ ] Amputation
[ ]Post-Concussion Syndrome	[ ] Blast Injury	[ ] Hearing Loss / Tinnitus
[ ]PTSD	[ ] Burn Injury	[ ] Chemical/Toxin Exposure
[ ]Chronic Pain Syndrome	[ ] Spinal Cord Injury	[ ] Other:

Primary Conditions And Reason For Stem Cell Therapy?

What is the primary condition you are seeking stem cell therapy for?

How long have you had these conditions?

How did it start?

[ ]Injury	[ ] Surgery-related	[ ] Congenital
[ ]Gradual onset	[ ] Military Service	[ ] Unknown

If injury, describe:

Date of onset/injury:

Orthopedic, Spine, Musculoskeletal Conditions (Check All That Apply)

Spine:

[ ]Degenerative Disc Disease- Level(s):

[ ]Herniated Disc(s)- Level(s):

[ ]Bulging Disc(s)- Level(s):

[ ]Spinal Stenosis- [ ] Cervical [ ] Thoracic [ ]Lumbar

[ ]Spondylolisthesis- Level(s)

[ ]Scoliosis

[ ]Spinal Cord Injury- Level:

[ ]Compression Fracture(s)- Level(s):

[ ] Facet Joint Syndrome

[ ] Radiculopathy- Location:

[ ] Spondylosis

[ ] Ankylosing Spondylitis

[ ] Failed Back Surgery Syndrome

[ ] Sciatica

[ ] Sacroiliac Joint Dysfunction

Send all MRI Imaging to Records@stemcells.world Attention Tracey Schaper

Orthopedic, Spine, Musculoskeletal Conditions (Check All That Apply)

Joint / Orthopedic:

[ ]Osteoarthritis- Location(s):

[ ]Rheumatoid Arthritis- Location(s):

[ ]Psoriatic Arthritis Location:

[ ]Bone-on-Bone Joint- Location(s):

[ ]Rotator Cuff Injury- [ ] Left [ ] Right [ ] Partial tear [ ] Full tear

[ ]Meniscal Tear- [ ]Left Knee [ ]Right Knee

[ ] Frozen Shoulder- [ ] Left [ ] Right

[ ] Avascular Necrosis (AVN)- Location:

[ ] Osteochondral Defect-

[ ] Chondromalacia Patellae- [ ] Left [ ] Right

[ ] Plantar Fasciitis- [ ] Left [ ] Right

[ ]ACL/PCL/MCL/LCL Injury- Which:

[ ] Bone Fracture(non-healing/delayed union)- Location:

[ ]Labral Tear- [ ] Hip [ ] Shoulder [ ]Left [ ] Right

[ ] Total Joint Replacement- Location: Date:

[ ] Total Joint Replacement- Location: Date:

[ ] Total Joint Replacement- Location: Date:

Orthopedic, Spine, Musculoskeletal Conditions (Check All That Apply)

Muscle / Tendon / Ligament:

[ ]Tendinitis- Location: [ ] Carpal Tunnel Syndrome

[ ]Tendinopathy- Location: [ ] Tennis Elbow / Golfer’s elbow

[ ]Ligament Injury- Location: [ ] Achilles Tendon Injury

[ ]Muscle Tear- Location [ ] IT Band Syndrome

[ ]Bursitis- Location: [ ] Shin Splints / Stress Fractures

Orthopedic, Spine, Musculoskeletal Conditions (Check All That Apply)

Nerve:

[ ]Nerve Damage/Neuropathy- Location: [ ] Pinched Nerve- Location:

[ ]Peripheral Neuropathy- Cause: [ ] Complex Regional Pain
Syndrome (CRPS)

Diseases And Disorders (Check All That Apply)

Neurological:

[ ]Traumatic Brain Injury (TBI)- Date of Injury: [ ] Stroke / Stroke Recovery- Date:

[ ]Post-Concussion Syndrome [ ] Seizure Disorder / Epilepsy-
Type:

[ ]Cognitive Impairment [ ] Cerebral Palsy

[ ]CTE (Chronic Traumatic Encephalopathy) [ ] Spinal Cord Injury

[ ]Multiple Sclerosis- Type: [ ] Neuro-Inflammation

[ ]Parkinson’s Diesease- Date diagnosed: [ ] Spasticity

[ ]ALS (Lou Gehrig’s Disease) [ ] Diffuse Axonal Injury

[ ]Cerebral Edema [ ] Autism Spectrum Disorder-
Level:

[ ]Hypoxic-Ischemic Injury [ ] Alzheimer’s Disease

Diseases And Disorders (Check All That Apply)

Autoimmune:

[ ]Lupus (SLE)

[ ]Rheumatoid Arthritis

[ ]Hashimoto's Thyroiditis

[ ]Scleroderma

[ ]Psoriatic Arthritis

[ ]Ankylosing Spondylitis

[ ] Sjogren's Syndrome

[ ] Celiac Disease

[ ] Myasthenia Gravis

[ ] Graves' Disease

[ ] Other:

Diseases And Disorders (Check All That Apply)

Pulmonary / Respiratory:

[ ]COPD

[ ]Asthma

[ ]Pulmonary Dibrosis

[ ] Pneumonia (recurring)

[ ] Lung Disease- Type:

[ ] Sleep Apnea

Diseases And Disorders (Check All That Apply)

Gastrointestinal:

[ ]Crohn's Disease

[ ]Ulcerative Colitis

[ ]IBS

[ ] Liver Dysfunction / Cirrhosis

[ ] GERD

[ ] Other:

Diseases And Disorders (Check All That Apply)

Cardiovascular:

[ ]Heart Failure / Cardiomyopathy

[ ]Cardiovascular Disease

[ ]Peripheral Artery Disease

[ ] History of Hert Attack- Date:

[ ] Arrhythmia- Type:

[ ] Other:

Diseases And Disorders (Check All That Apply)

Metabolic / Endocrine:

[ ]Diabetes- [ ] Type 1 [ ] Type 2 [ ] Pre-diabetic [ ] Thyroid Disorder- Type:

[ ]Osteoporosis / Osteopenia

[ ]Kidney Disease- Stage:

[ ]Obesity

[ ]Adrenal Insufficiency

[ ]Other:

Diseases And Disorders (Check All That Apply)

Behavioral / Psychological:

[ ]PTSD

[ ]Depression

[ ]Anxiety

[ ]Behavioral Disorders

[ ] Substance Use Disorder- Type:

[ ] OCD

[ ] Bipolar Disorder

[ ] Other:

Diseases And Disorders (Check All That Apply)

Oncology:

[ ]Cancer- Type:

[ ]In remission since:

[ ]Currently undergoing treatment

[ ] History of chemotherapy- Last treatment:

[ ] History of radiation- Last treatment:

[ ] History of immunotherapy

Diseases And Disorders (Check All That Apply)

Dermatological:

[ ]Psoriasis

[ ]Eczema / Atopic Dermatitis

[ ] Chronic wounds / non-healing wounds

[ ] Alopecia

[ ] Scar tissue(excessive)

Diseases And Disorders (Check All That Apply)

Sexual Health:

[ ]Erectile Dysfunction

[ ] Peyronie’s Disease

[ ] Decreased libido related to medical conditions

Diseases And Disorders (Check All That Apply)

Other:

[ ]Fibromyalgia	[ ] Long COVID
[ ]Chronic Fatigue Syndrome	[ ] Anti-Aging / Longevity
[ ]TMJ	[ ] HIV/AIDS
[ ]Dry Mouth	[ ] Other:
[ ]Lyme Disease	

Pain Assessment (If Applicable)

Current pain Level (0-10): At rest ___ During activity ___ At worst ___

Pain Location(s):

Pain Description:

[ ] Sharp [ ] Dull [ ] Burning [ ] Tingling [ ] Numbness [ ] Shooting [ ] Throbbing [ ] Stiffness

How long have you been in pain?

What makes it worse:

What makes it better:

Allergy And Sensitivity Screening

Do you have any known drug allergies? [ ] Yes [ ] No

If yes, List drug and reaction:

Do you have any food allergies? [ ] Yes [ ] No

If yes, list:

Do you have any environmental allergies? [ ] Yes [ ] No

If yes, describe reaction:

Allergy Or Sensitivity to SULFUR or SULFA Drugs?

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Allergy Or Sensitivity to DMSO (Dimethyl Sulfoxide)

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Allergy Or Sensitivity to BENADRYL (Diphenhydramine)

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Allergy Or Sensitivity to ASPIRIN Or NSAIDs

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Allergy Or Sensitivity to HEPARIN

[ ]Yes [ ] No [ ] Unknown

Have you ever been diagnosed with Herparin-Induced Thrombocytopenia (HIT)? [ ] Yes [ ] No

Allergy Or Sensitivity to SALINE (Sodium Chloride)

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Allergy Or Sensitivity to LACTATED RINGER'S Solution?

[ ]Yes [ ] No [ ] Unknown

If yes, describe reaction:

Have You Ever Had An Allergic Reaction During or After An IV Infusion?

[ ]Yes [ ] No

If yes, what triggered it:

Have You Ever Had An Anaphylactic Reaction To Anything?

[ ]Yes [ ] No

If yes, what triggered it:

Do you carry an EpiPen? [ ] Yes [ ] No

Blood Clotting And Bleeding History

History of blood clotting disorders? [ ] Yes [ ] No

If yes, type:

[ ]DVT [ ] PE [ ] Factory V Leiden [ ] Protein C/S deficiency [ ] Antiphospholipid Syndrome [ ] Other:

Date of last clotting event:

History of excessive bleeding or bruising? [ ] Yes [ ] No

Difficulty stopping bleeding after surgery or dental work? [ ] Yes [ ] No

Family history of clotting or bleeding disorders? [ ] Yes [ ] No

Currently on blood thinners? [ ] Yes [ ] No

If yes, which:

[ ]Warfarin/Coumadin [ ] Eliquis [ ] Xarelto [ ] Heparin [ ] Aspirin [ ] Plavix [ ] Other:

Methylation Status

Do you have known problems with methylation? [ ] Yes [ ] No [ ] Unknown

Have you ever been tested for MTHFR genemutation? [ ] Yes [ ] No

If yes, result:

[ ]Heterozygous (one copy) [ ] Homozygous (two copies) [ ] Normal [ ] Unknown

Difficulty processing B vitamins? [ ] Yes [ ] No [ ] Unknown

Currently taking methylated B vitamins (methylfolate, methylcobalamin) [ ] Yes [ ] No

Ever been told you have high homocysteine levels? [ ] Yes [ ] No

Methylation Status

Do you have known problems with methylation? [ ] Yes [ ] No [ ] Unknown

Have you ever been tested for MTHFR genemutation? [ ] Yes [ ] No

If yes, result:

[ ]Heterozygous (one copy) [ ] Homozygous (two copies) [ ] Normal [ ] Unknown

Difficulty processing B vitamins? [ ] Yes [ ] No [ ] Unknown

Currently taking methylated B vitamins (methylfolate, methylcobalamin) [ ] Yes [ ] No

Ever been told you have high homocysteine levels? [ ] Yes [ ] No

Current Medications (List all - prescription and OTC)

Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:
Medication:	Dose:	Frequency:	Purpose:

Current Vitamins And Supplements

Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:
Supplement:	Dose:	Frequency:

Current Therapies And Treatments

Are you currently receiving any of the following?

[ ]Physical therapy- Provider: Frequency:

[ ]Occupational therapy- Provider: Frequency:

[ ]Chiropractic care- Provider: Frequency:

[ ]Acupuncture- Provider: Frequency:

[ ]Massage therapy- Frequency:

[ ]Pain Management- Provider:

[ ]Counseling/Therapy- Provider:

[ ]Speech Therapy- Provider:

[ ]Hyperbaric oxygen therapy- Provider:

[ ]IV therapy/Infusions- Provider:

[ ]Peptide therapy- Provider:

[ ]Hormone replacement therapy- Provider:

[ ]Other:

Current Medical Care

Are you currently under the care of any physician(s)? [ ] Yes [ ] No

Primary Care Physician:

Phone: Fax:

Last visit:

Specialist 1:

Specialty:

Phone: Last visit:

Specialist 2:

Specialty:

Phone: Last visit:

Specialist 3:

Specialty:

Phone: Last visit:

Surgical Care

List all previous surgeries with approximate dates:

Surgery:	Date:	Outcome:
Surgery:	Date:	Outcome:
Surgery:	Date:	Outcome:
Surgery:	Date:	Outcome:

Previous Stem Cell Or Regenerative Treatments

Have you ever received stem cell therapy? [ ] Yes [ ] No

If yes:

Date(s):

Type of cells:

Provider/clinic:

Route: [ ] IV [ ] Injection [ ] Intrathecal [ ] Other:

Results:

Have you ever received PRP (Platelet-Rich Plasma)? [ ] Yes [ ] No

If yes, date/provider/results:

Have you ever received exosome therapy? [ ] Yes [ ] No

If yes, date/provider/results:

Other regenerative treatments:

Family Medical History

Heart disease: [ ] Yes [ ] No- Who:

Cancer: [ ] Yes [ ] No- Type/Who:

Diabetes: [ ] Yes [ ] No- Who:

Autoimmune disease: [ ] Yes [ ] No- Type/Who:

Neurological disease: [ ] Yes [ ] No- Type/Who:

Blood clotting disorders: [ ] Yes [ ] No- Who:

Arthritis: [ ] Yes [ ] No- Who:

Osteoporosis: [ ] Yes [ ] No

Mental health conditions: [ ] Yes [ ] No- Type/Who:

Genetic conditions: [ ] Yes [ ] No- Type/Who:

Lifestyle And Daily Activity

Occupation:

Employment status:

[ ]Employed [ ] Self-employed [ ] Retired [ ] Disabled [ ] Unemployed [ ] Student [ ] Military(active)

Is your day primarily:

[ ]Sitting [ ] Standing [ ] Mixed [ ] Physical labor [ ] Bedbound

Hours per day sitting: Hours per day standing: Hours per day walking: Hours per day driving:

Do you exercise? [ ] Yes [ ] No

If yes, type and frequency:

Do you smoke or use tobacco? [ ] Yes [ ] No [ ] Former

If yes/former: Type: How much: Years:

Quit date (if former):

Alcohol use: [ ] None [ ] Occasional [ ] Moderate [ ] Heavy

Drinks per week:

Recreational drug use: [ ]None [ ] Marijuana [ ] Other

Diet: [ ] Standard [ ] Vegetarian [ ] Vegan [ ] Keto [ ] Paleo [ ] Mediterranean [ ] Other:

Sleep quality: [ ] Good [ ] Fair [ ] Poor Average hours per night:

Do you use any sleep aid? [ ] Yes [ ] No- What:

Treatment Goals

What is your primary goal with stem cell research therapy? (Check All That Apply)

[ ]Pain reduction	[ ] Improved cognitive function	[ ] Return to work
[ ]Improved mobility/range of motion	[ ] Reduced inflammation	[ ] Return to sport/physical activity
[ ]Avoid surgery	[ ] Tissue/cartilage regeneration	[ ] Anti-aging / longevity
[ ]Post-surgical recovery/enhancement	[ ] Bone healing	[ ] Immune system support
[ ]Disease management/improvement	[ ] Nerve repair	[ ] Other:
[ ]Neurological recovery	[ ] Improved quality of life	
[ ]Improved breathing/lung function	[ ] Reduced dependence on medication	

In your own words, what does a successful outcome look like for you?

On a scale of 1-10, how much is your condition currently affecting your quality of life? :

Imaging And Records

What is your primary goal with stem cell research therapy? (Check All That Apply)

Do you have recent imaging (MRI, X-Ray, Ultrasound)? [ ] Yes [ ] No

If yes:

Type: [ ] MRI [ ] CT [ ] X-ray [ ] Ultrasound [ ] EMG/NCS [ ] Other:

Date of most recent imaging:

Facility:

Body part imaged:

Findings (if known):

Please email all available imaging and relevant medical records to:

records@stemcell.world

Include your full name and date of birth in the subject line.

[ ]I have sent my records to records@stemcells.world

[ ] I will send my records before my appointment

[ ]I need help obtaining my records

[ ] I do not have recent imaging

Laboratory Work

Have you had lab work completed in the last 6 months? [ ] Yes [ ] No

If yes, please send results to: **records@stemcells.world**

Date of most recent labs:

Ordering physician:

Labs completed (check all that apply):

[ ]CBC with Differential

[ ]CMP (Comprehensive Metabolic Panel)

[ ]Inflammatory Markers (CRP, ESR)

[ ]Coagulation Panel (PT/INR, PTT)

[ ]Vitamin D

[ ]Iron/Ferritin

[ ] B12 / Folate

[ ] Hemoglobin A1c

[ ] Thyroid Panel

[ ] Homocysteine

[ ] Lipid Panel

[ ] Urinalysis

[ ] Genetic/MTHFR testing

[ ] Other:

Additional Information

Is there anything else about your health, history, or goals that you would like us to know?

Consent And Acknowledgment

By signing below, I acknowledge that:

1. I am voluntarily participating in a clinical research study utilizing PremierMax® CB, an FDA IND-authorized (IND #27871) minimally manipulated umbilical cord blood stem cell product.
2. All information provided on this form is true and accurate to the best of my knowledge.
3. My medical information will be kept confidential and protected under HIPAA. De-identified data may be used for research purposes and publication.
4. I understand that stem cell therapy is investigational and results are not guaranteed.
5. I have the right to withdraw from the study at any time.
6. I will notify the research team if I experience any changes in my health or adverse effects.

Patient Signature: Date:

Print Name:

Parent/Legal Guardian Signature (if patient is a minor):

Signature: Date:

Print Name: Relationship:

Staff Use Only

Intake completed by: Date: Time:

Physician review: [ ] Pending [ ] Completed Date:

Imaging receive: [ ] Yes [ ] No [ ] Pending

Labs received: [ ] Yes [ ] No [ ] Pending

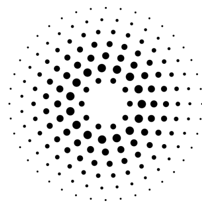
Treatment plan:

Assigned protocol arm:

Product lot number:

Allograft Tracing Record initiated: [ ] Yes [ ] No

Powered By



KALBIO

BIOTECHNOLOGY