Scottsdale Regenerative Medicine & Wellness

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New Patient Injection Intake Form

Date: _____
Name: _____Age _____Date of Birth_____
Home Address: _____
City_____State_____Zip_____
Home Phone _____Work Phone _____Cell Phone_____
E-mail_____
Married_____Single_____Divorced_____Widowed____
Spouse's Name_____
Physician _____Phone #_____
Contact in case of emergency: _____Phone #_____

Please indicate how you found out about our office?
_____ Newspaper- Which one? _____
_____ Health Magazine- Which one? _____
_____ Local talk or lecture- Which one? _____
_____ Internet- Which category? _____
_____ Doctor referral- Who? _____
_____ Friend or Relative- Who? _____

I will be paying by CASH_____CHECK_____CREDIT CARD_____

- **I Understand and agree that, regardless of my insurance status, I am responsible for all charges at this office at the time professional services are rendered. I agree to the services and fees rendered in this office and that they will not be subject to dispute by my insurance company.**
- **I certify that the information on this patient information form is true and correct to the best of my ability.**
- **I agree to notify you of any changes in my health status, address, etc.**
- **I understand that there is an OFFICE VISIT CHARGE for evaluation or re-evaluation for all visits, in addition to any TREATMENT CHARGE.**
- **I understand that this office is NOT A MEDICARE PROVIDER and Medicare will NOT reimburse me for my medical expenses here and I will NOT submit any claims from this office to Medicare.**
- **I understand that the Doctor or his staff will not submit claims to Medicare and that the doctor will not receive any direct or indirect payments from Medicare or Medicare related plans.**

- **I understand that this office is not a provider for other health care plans or insurance and that this office will not submit claims to them.**
- **I understand that the Doctor does not provide emergency or urgent care services as defined in the Social Security Act.**
- **I understand that all services normally covered by Medicare, such as X-Rays, Lab work and physical therapy, will not be covered under this Doctor's prescription.**

- ***Release of Information:***
  Unless I indicate otherwise, I give Dr. Fred Arnold and Staff of Scottsdale Regenerative Medicine & Wellness permission to discuss and/or release my personal health information to family members, other physicians, testing facilities, and diagnostic centers on an individual basis.
  If there is any specific person or organization, I do not wish my personal health information to be released to, I will indicate that on this form:
  Do not discuss or release my personal health information to the following:

  _____ Anyone or any organization.

  _____The following specific individual(s) or organization(s):

  1.
  2.
  3.

Patient's Signature_____Date_____

NAME_____, Age_____, Date_____
Handedness: Rt____, Lt ____Occupation_____, full time( ), part time( ) or retired ( ); change in work because of medical condition? Yes ( ), No ( ). Favorite sport / exercise _____Any change in sport / exercise because of medical condition? Yes ( ), No ( )
Chief complaint or problem: (1)_____
Onset date: _____, auto accident? _____, other injury? _____other cause?_____
Pain or symptom intensity level? Circle one: 0 (none), 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (max)
Describe this problem briefly:_____
_____
Other problems you are being seen for: (2)_____
_____Onset date:_____, Pain or symptoms level (0 to 10)_____
(3)_____Onset date:_____, Pain or symptoms level (0 to 10)_____
(4)_____Onset date:_____, Pain or symptoms level (0 to 10)_____
(5)_____Onset date:_____, Pain or symptoms level (0 to 10)_____
What studies have you had for these problems?_____
What treatments have you had for these problems?_____
_____
What if any, surgery has been recommended for these problems?_____
What surgeries have you had for these or any other problems?_____
_____
Last Mammogram___/___/___Results _____Last pap smear / prostate check___/___/___
Martial status: (S) (M) (D) (W)
Smoke: (no) quit ___/___/___.(yes) PPD#_____. Drink: alcohol (no) (oz's/day_____). Coffee (no) (cups/day_____). Other (none):_____
FAMILY medical history of: Cancer? (none)_____Diabetes? (none)_____
Heart disease? (none)_____.TB (none)_____Other?_____
Present Weight: _____Weight one year ago: _____Ideal Weight:_____
Height:_____

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

Drug	**Dosage**	**Frequency/How Often**	**Purpose**

Supplements:	**Dosage:**	**Frequency/How Often**	**Purpose**

Please List All Sensitivities/Allergies/Reactions:

Drugs: _____Foods: _____

Environment: _____

Review of Symptoms: Please circle all words that apply to you:

Appetite change, Weight change, Fever, Chills, Malaise, Fatigue, Itching, Rash, Hives Skin cancer, other cancer, Seasonal allergy, Hearing change, ringing in ears, Nose bleeds, Vision change, Headaches, Dizziness, Shortness of breath, Cough, Wheezing, Chest pain, Edema (swelling), fainting Spells, Indigestion, Nausea, Abdominal pain, Bowel Change, diarrhea, Constipation, Bloody stool, Dysuria (burning urination), Hematuria (blood in urine, Nocturia (getting up at night to urinate), Decreased urine force or flow, Urethral discharge, Vaginal discharge, Diabetes, Thyroid, Periods (y) (n) (change), Breast mass/discharge, Desires/ability changes, Joint pains, Muscle aches, Bursitis, Gout History, Stiffness, Osteoporosis, Neck pain, Back pain, Epilepsy, Palsy, Tremor (shaky hands), Stroke, Speech, Memory, Weakness, Tingling, Numbness, Anxious, Depressed, Stress, Anemia, Bruise easily, Swollen glands. Other symptoms:_____

_____

PAIN DIAGRAM

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = Ache **B** = Burning **S** = Stabbing **N** = Numbness **P** = Pins & Needles **O** = Other