## New Patient General Intake Form

# Scottsdale Regenerative Medicine & Wellness

**Fred G. Arnold, N.M.D.**
**7595 East McDonald Drive, Suite 100**
**Scottsdale, AZ 85250**
**(O) 602 292-2978 Fax: 480-219-8132**
www.scottsdalenaturalpain.net

Date:_____

Name:_____Date of Birth:_____Age:____
Street Address:_____
City:_____ State:_____ Zip:_____
Home phone: _____Work Phone:_____Cell Phone:_____
E-mail_____
Highest level of education: _____
Occupation:_____Employer_____Hours work per week:_____
Marital Status (circle): Single Married Separated Divorced with Partner Widow(er)
Spouse's Name_____
Person to call in case of Emergency:_____Relationship to you:_____
Phone number contact for them: _____

Regular Physician: _____ 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? _____**

List in Order of Importance what your concerns are:

| |
|---|
| 1- |
| 2- |
| 3- |
| 4- |
| 5- |

Last time you had blood work done and with what doctor:_____

**Family history**

| | Father | Mother | Grandparents |
|---|---|---|---|
| Age if living | _____ | _____ | _____ |
| Age when died | _____ | _____ | _____ |
| High Blood Pressure | Y N | Y N | Y N |
| Heart disease | Y N | Y N | Y N |
| Asthma/allergies | Y N | Y N | Y N |
| Auto-immune disease | Y N | Y N | Y N |
| Diabetes Mellitus | Y N | Y N | Y N |
| Osteoporosis | Y N | Y N | Y N |

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

List **Y**es, **N**o, or **P**ast regarding use of the following:

Antacids: Y N P Steroids: Y N P

Smoking: Y N P Packs per day if Yes/Past: _____

Analgesics: Y N P Laxatives: Y N P

Coffee: Y N P Cups per day if Yes/Past: _____

Soda Pop: Y N P Ounces per day if Yes/Past: _____

Alcohol: Y N P How often and how much if Yes/Past: _____

Any alcohol addiction: Y N P

Any alcohol treatment: Y N P

Recreational drugs: Y N P

Any drugs addiction: Y N P

Any drug treatment: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

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

**Page 3:**

| Supplements: | Dosage | Frequency/How Often | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Review Of Systems:**

Present Weight: _____ Weight one year ago: _____
Height: _____
Ideal Weight: _____

**Overall Energy Level:** 0 (the worst) to 10 (the best) – circle the level that best describes your energy level now.

0 1 2 3 4 5 6 7 8 9 10

If you have fatigue, when in morning, afternoon, evening is it the worst?:_____
If you have fatigue, can you do what you need to during the day ?: Y N

**Overall Sleep Level:** 0 (the worst) to 10 (the best) – circle the level that best describes your quality of sleep now.

0 1 2 3 4 5 6 7 8 9 10

**Overall Digestion Level:** 0 (the worst) to 10 (the best) – circle the level that best describes your quality of digestion now.

0 1 2 3 4 5 6 7 8 9 10

**Overall Stress Level:** 0 (the worst) to 10 (the best) – circle the level that best describes your stress level now.

0 1 2 3 4 5 6 7 8 9 10

**REGARDING THE NEXT LONG SECTION:**
**Please Circle Y** if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

**Skin**:

Rash: Y N P
Hives: Y N P
Psoriasis/eczema: Y N P
Dry: Y N P
Cancer: Y N P
Color Change: Y N P
Lump: Y N P
Itchy: Y N P
Perspiration: Y N P

**Page 4:**

**Head**:

Headache: Y N P
Dandruff: Y N P
Oil/dry hair: Y N P
Migraine: Y N P
Head Injury: Y N P
Hair loss: Y N P

**Eyes**:

Dry/Watery: Y N P
Double vision: Y N P
Glaucoma: Y N P
Strain: Y N P
Itchy: Y N P
Blurry vision: Y N P
Cataracts: Y N P
Dark under eyelid: Y N P
Discharge: Y N P

**Nose**:

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P
Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

**Mouth/Throat**:

Canker sores: Y N P
Sore throat: Y N P
Dentures: Y N P
Loss of taste: Y N P
Cold sores: Y N P
Gum disease: Y N P
Hoarseness: Y N P

**Neck**:

Stiffness: Y N P
Full movement: Y N P
Swollen glands: Y N P
Tension: Y N P

**Respiratory:**

Cough: Y N P
Shortness of breath with exertion: Y N P
Pneumonia: Y N P
Asthma: Y N P
Wheezing: Y N P
Bronchitis: Y N P
Painful breathing: Y N P

**Cardiovascular:**

High blood pressure: Y N P
Low blood pressure: Y N P
Arrhythmias: Y N P
Swelling: Y N P
Murmurs: Y N P
Palpitations: Y N P
Chest pain: Y N P

**Gastrointestinal:**

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea: Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P
Bowel movement frequency:_____
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

**Page 5:**

## Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P
Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

## Male Genitalia: (Male Only)

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P
Sexually active: Y N P
Sexually transmitted disease: Y N P
Prostate disease/symptoms: Y N P

## Female Genitalia: (Female Only)

Age periods began:_____
How long periods last: _____
**Date of last period**:_____
**Periods:**
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear:_____
**Diagnosis:** _____
Any abnormal paps: Y N P
When was abnormal: Y N P
How often periods occur:_____
**Menopausal since what age:**_____
Times Pregnant:_____
How many births:_____
Miscarriages:_____
Abortions:_____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P
Vaginitis: Y N P
Any Birth Control (please list types and ages used):_____
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results:_____
Use of Hormones: Y N P

## Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P
Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

## Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

## Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P
Anger/irritability: Y N P
High Stress: Y N P
Fear/Panic: Y N P

**Page 6**:

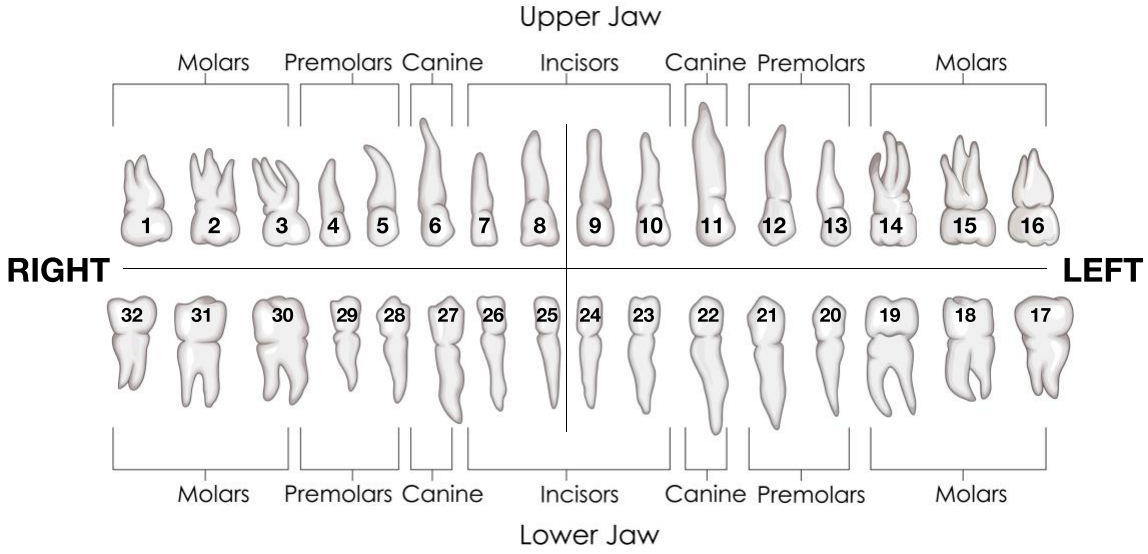
**Exercise:**
How often:_____
What type(s):_____
For How long:_____

**Sleep:**
How long per night: _____
If you wake up frequently, what is the reason: _____
Nightmares: Y N P
Wake refreshed: Y N P
Must Nap during the day: Y N P
Sleep walk: Y N P
Grind Teeth: Y N P
Snore: Y N P

**Food:**
Appetite Good? Y N P
Foods crave: _____
Foods Dislike: _____
Foods that don't sit well:_____

**Dental Chart:**
On the Dental Chart below, please indicate date(s) incurred & your age at that time each of the following dental procedures

- Amalgam (silver) fillings (AF)
- Root Canal Teeth (RCT)
- Dental Implants (DI)
- Dental extractions (DE)
- Other dental procedures (indicate the procedure)



**Page 7:**

**Health Line:**
Indicate any health condition(s) and your age (yo) when it started on the time line below:
***Example:*** root canal, age 20yo; diabetes, age 42, yo; hypertension, age 49; etc

***Example*** 20 yo Root Canal 49 yo hypertension

Birth 10 yo 20 yo 30 yo 40 yo 50 yo 60 yo 70 yo 80 yo 90 yo

42 yo diabetes

Birth 10 yo 20 yo 30 yo 40 yo 50 yo 60 yo 70 yo 80 yo 90 yo

## BUSINESS INFORMATION:

**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.**

**Page 8:**

***Release of Information:***

**Unless I indicate otherwise, I give the Doctor(s) 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_____**