Pacific Stem Cells

STEM CELL CONSULT QUESTIONNAIRE

TODAY'S DATE ______________

PATIENT'S DEMOGRAPHICS:

PATIENT'S FIRST NAME _____________________________ LAST NAME ___________________________________

DATE OF BIRTH ______________ AGE _____ SOCIAL SECURITY # ________________________ SEX: Male Female

HOME PHONE _________________ CELL or WORK PHONE ________________ E-MAIL ________________________

HOME ADDRESS ____

CITY ____ STATE ____________ ZIP ___________________

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME _______________________________ RELATION TO PATIENT ________________

PRIMARY PHONE # _____________________________ ALTERNATE PHONE #_______________________________

EMERGENCY CONTACT NAME _______________________________ RELATION TO PATIENT ________________

PRIMARY PHONE # _____________________________ ALTERNATE PHONE #_______________________________

EMPLOYMENT INFORMATION:

COMPANY ____ PHONE __________________________

ADDRESS ____

CITY ____ STATE _______________ ZIP ____________________

INSURANCE INFORMATION:

INSURANCE COMPANY NAME (**PRIMARY**) ____

MEMBER ID # ______________________________________ GROUP # __________________ HMO/EPO? YES / NO

PRIMARY PHYSICIAN: _______________________________PHONE __________________________

ADDRESS: ____

REFERRING PHYSICIAN: ____ PHONE __________________________

ADDRESS: ____

PHARMACY:

NAME ____________________________ ADDRESS: __________________________________

PHONE: ____________________________ FAX: _______________________________

PATIENT: ________________ **(last),** ______________ **(first)** **DATE:** ___ / ___ / ____

BRIEFLY DESCRIBE THE CHARACTER OF YOUR PAIN & SYMPTOMS (e.g. SHARP, RADIATING PAIN, TINGILING, DULL, ACHE, SHOOTING, BURNING, NUMB, HOT COLD)__________________________

____

____

LOCATION OF SYMPTOMS:____

____

PAIN/ SYMPTOM LEVEL SCALE: 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE

WHAT TREATMENTS HAVE YOU HAD?

	DATES DONE	DID THIS HELP?	
EPIDURAL INJECTIONS	____________________	YES	NO
FACET INJECTIONS (MEDIAL BRANCH BLOCK)	____________________	YES	NO
TRIGGER POINT INJECTIONS	____________________	YES	NO
JOINT INJECTIONS	____________________	YES	NO
STEM CELL	____________________	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 (Dr.)

DO YOU TAKE **BLOOD THINNERS**? YES NO (DRUG NAME AND DOSE) ________________________
(Omega-3, baby aspirin, fish oil, Vitamin E, Flax seed oil)

ALLERGIES/INTOLERANCE: DO YOU HAVE ANY **ALLERGIES TO MEDICATIONS**? YES NO

LIST DRUGS AND TYPE OF REACTIONS______________________________________

CHECK IF YOU ARE ALLERGIC TO: ☐**SHELLFISH** ☐**IV CONTRAST DYE** ☐**LATEX** ☐**ADHESIVE (BAND-AID)**

DO YOU HAVE ANY **ALLERGIES TO FOOD, INSECT STINGS, OR OTHER ALLERGIES?** YES NO

PACIFIC STEM CELLS

PATIENT: __________________ (last), _______________ (first) DATE: ____ / ____ / _____

IF YES, PLEASE LIST:____

PAST MEDICAL PROBLEMS HISTORY: (Circle all conditions you have or had in the past)

HEART ATTACK	ASTHMA	PROSTATE PROBLEM	ARTHRITIS
HEART DISEASE	DIABETES	STOMACH ULCER	INTESTINAL PROBLEMS
ANGINA (CHEST PAIN)	CANCER	PREGNANCY (X__)	C-SECTIONS (X___)
STROKE	LIVER PROBLEMS	SEIZURES	OTHERS: ______________________________
HIGH BLOOD PRESSURE	TUBERCULOSIS	KIDNEY PROBLEMS	______________________________
DEPRESSION	LUNG PROBLEMS	BLEEDING PROBLEMS	PREVIOUS INJURIES: DATE_____________
THYROID PROBLEMS	ANXIETY	SLEEPING DIFFICULTIES	WHAT BODY PART? ___________________

Any other relevant medical history? ____

____

SURGICAL HISTORY:

SURGERY	DATE (Most Recent First)	PHYSICIAN
______________________________	_________________	________________________
______________________________	_________________	________________________
______________________________	_________________	________________________
______________________________	_________________	________________________
______________________________	_________________	________________________

Any other relevant surgical or medical procedure history? ____

____

How many hours ago was your last meal? __________

FAMILY HISTORY: (i.e., Joint/Back Problems, Arthritis, Cancer, Lung Problems, Heart Disease, etc.)

			Please List Known Conditions	
Father:	Alive	Deceased	______________________	______________________
Mother:	Alive	Deceased	______________________	______________________
Children:	Alive	Deceased	______________________	______________________
Siblings:	Alive	Deceased	______________________	______________________
Paternal Grandfather:	Alive	Deceased	______________________	______________________
Paternal Grandmother:	Alive	Deceased	______________________	______________________
Maternal Grandfather:	Alive	Deceased	______________________	______________________
Maternal Grandmother:	Alive	Deceased	______________________	______________________

PACIFIC STEM CELLS

PATIENT: __________________ **(last),** _______________ **(first)** **DATE:** ____ / ____ / _____

SOCIAL HISTORY:

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPERATED

CHILDREN: HOW MANY? BOY(S)________ GIRL(S)__________HOW MANY LIVE WITH YOU? ___________

SPECIAL DIET: VEGETARIAN FLEXITARIAN LACTO-OVO PESCATARIAN VEGAN RAW MICROBIOTIC

EDUCATION: LAST GRADE COMPLETED: ____________________

TOBACCO? – PACKS/DAY_________ PRESENTLY or ________ years SINCE YOU QUIT

ALCOHOL – DRINKS / DAY or WEEK _____ WHAT? _________________________

ACTIVITIES / EXERCISE YOU DID PRIOR TO YOUR INJURY ____

STREET DRUGS or PAST DRUG DEPENDENCY? YES NO WHAT? _____________________________________

OCCUPATION ________________________________

BRIEFLY DESCRIBE WHAT YOU DO AT WORK: ____

INITIAL VITAL SIGNS:

Height_________________ **Weight**_____________________

TO OUR PATIENTS:

AUTHORIZATION TO RELEASE MEDICAL RECORDS INFORMATION: I HEREBY AUTHORIZE THE DOCTOR RENDERING SERVICE TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

DATE _________________ PATIENT SIGNATURE _______________________________

ASSESSEMENT & PLAN:

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_________________________ _________________________ ________________

Provider Name **Provider Signature** **Evaluation Date**