Regenexx®
PITTSBURGH

(www.regenexxpittsburgh.com)

Patient Name_____ Date_____

Birthdate: _____/_____/_____ Age: _____ Sex: M_____ F_____ Height: _____ Weight:_____

Occupation: _____ How long? _____

How were you referred to RAPS: □ Physician □ family/friend □ magazine/newspaper □ physical therapist □ internet □ Pittsburgh marathon □ insurance company

Referring Physician: _____ PCP: _____

IF YOUR SYMPTOMS ARE THE RESULT OF AN INJURY, COMPLETE THE FOLLOWING:

Type of Injury: Work_____ Auto_____ Home_____ Other (explain)_____

Date of Injury: _____ Where it happened: _____

How it happened: _____

Are you currently off work due to this injury? _____ If yes, since what date? _____

HISTORY OF PRESENT ILLNESS

Date your symptoms began: _____ Describe your symptoms: _____

_____

_____

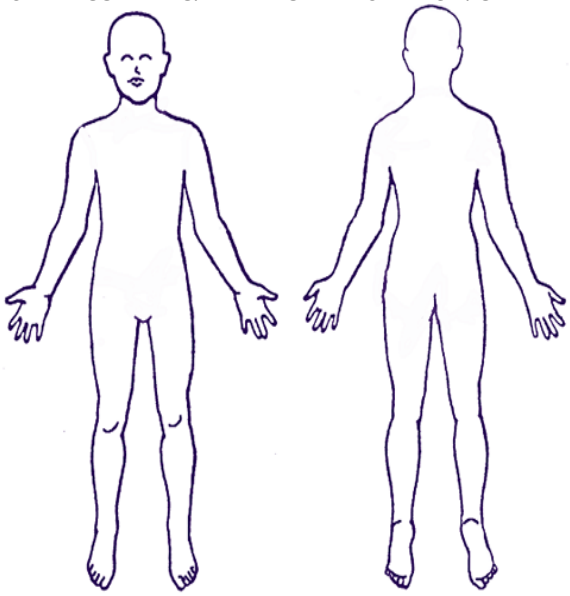
Is your pain (please Circle if applicable): **Sharp Dull Aching Stabbing Burning Tingling Numb**

Severity Rate: 1 (low) to 10 (high): _____ Have you had any loss of bowel/bladder control? _____

When do you have pain? Constantly Daily Weekly Monthly Other _____

Please mark the areas on your body where you feel the following sensations, using the symbols below:

* NUMBNESS : PINS/NEEDLES X BURNING / STABBING



Please circle yes or no to the following questions:

- Do you exercise regularly? Yes No
- Do you feel stressed on a regular basis? Yes No
- Do you describe your diet as healthy? Yes No
- Do you regularly feel fatigued (tired)? Yes No
- Do you sleep well? Yes No
- Do you feel well rested after a night's sleep? Yes No

What makes your pain worse?

_____

_____

What makes it better?

_____

_____

Patient Name _____ Date of Birth: _____

What treatment have you had for your complaints?

_____ Physical Therapy _____ Brace/Collar/Splint

_____ TENS Unit _____ Pain Clinic

_____ Chiropractor _____ Injections/Nerve Blocks

_____ Treatment by Another Physician

_____ Medications for pain (please list) _____

SOCIAL HISTORY

_____ Single _____ Married _____ Divorced _____ Widow(ed) __ ____ Partnered

Children? (number) _____

Smoker? YES NO Smoker in the past? YES NO ____ packs per day for _____ years.

Do you use smokeless tobacco (chew or snuff)? YES NO

Alcohol? YES NO _____ drinks per week Recreational drug use? YES NO

Exercise? YES NO If yes, describe type and frequency _____

_____

FAMILY HISTORY

Do any family members suffer from the following conditions? If so, who?

_____ Heart_____ _____ Diabetes _____

_____Cancer_____ _____ Stroke _____

_____Hypertension_____ _____ Aneurysm _____

PAST MEDICAL HISTORY

Do you suffer from any of the following conditions? Circle all that apply:

Cardiac:	Heart Attack	Abnormal Rhythm	Murmur	Other: _____
Pulmonary:	Asthma	COPD	Emphysema	Other: _____
Endocrine:	Diabetes	Hypothyroid	Pituitary tumor	Other: _____
Circulatory:	Hypertension	Stroke	Aneurysm	
	Bleeding disorders			
Cancer:	Type: _____		Date of Diagnosis: _____	

Other: _____

_____

Patient Name _____ Date of Birth: _____

REVIEW OF SYSTEMS (please circle all that apply)

Neurological:	Headache	Dizziness	Memory	Numbness
Eyes:	Glasses	Contact lenses	Blurriness	Double vision
Ears/Throat:	Deafness	Ringing	Swallowing	Hoarseness
Cardiac:	Chest pain	Skip beats	Rapid beats	Edema
Pulmonary:	Cough	Cough blood	Wheezing	Short of breath
Intestinal:	Constipation	Diarrhea	Incontinence	Bleeding
Urinary:	Frequent	Burning	Incontinence	Bleeding
Musculoskeletal:	Pain	Weakness	Arthritis	Cane/Walker
Endocrine:	Weight loss	Weight gain	Heat/Cold intolerance	
Skin:	Bruising	Lesions	Birthmarks	
Hematological:	Bleeding	Transfusion	Hepatitis	
Psychiatric:	Depression	Fatigue	Insomnia	

PREVIOUS SURGERIES (list type of surgery, date and name of the surgeon that performed it)

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

ALLERGIES: (list what you are allergic to and the reactions you have) **LATEX (circle) Y or N IODINE (circle) Y or N**

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

CURRENT MEDICATIONS (include over-the-counter medications taken on a regular basis)

PHARMACY NAME # _____ **PHONE** #_____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

DIAGNOSTIC STUDIES (list date and place your study was done)

X-rays _____ MRI _____

CT Scan _____ Myelogram _____

Bone Scan _____

Patient Signature Date

(PHYSICIAN USE ONLY): I personally reviewed all of the systems noted on page 3 of this patient history.