STILL WELL REGENERATIVE MEDICINE CENTER
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Patient Information

Name: ____ Date: __/__/___

Date of Birth: __/__/__ Age: ___ Male: ___ Female: ___

Martial Status:

SINGLE MARRIED DIVORCED SEPARATED WIDOW

* PLEASE ANSWER THESE QUESTIONS AS BEST YOU CAN. A THOROUGH RECORD IS IMPORTANT FOR THE BEST CARE.

General Information About Your Pain

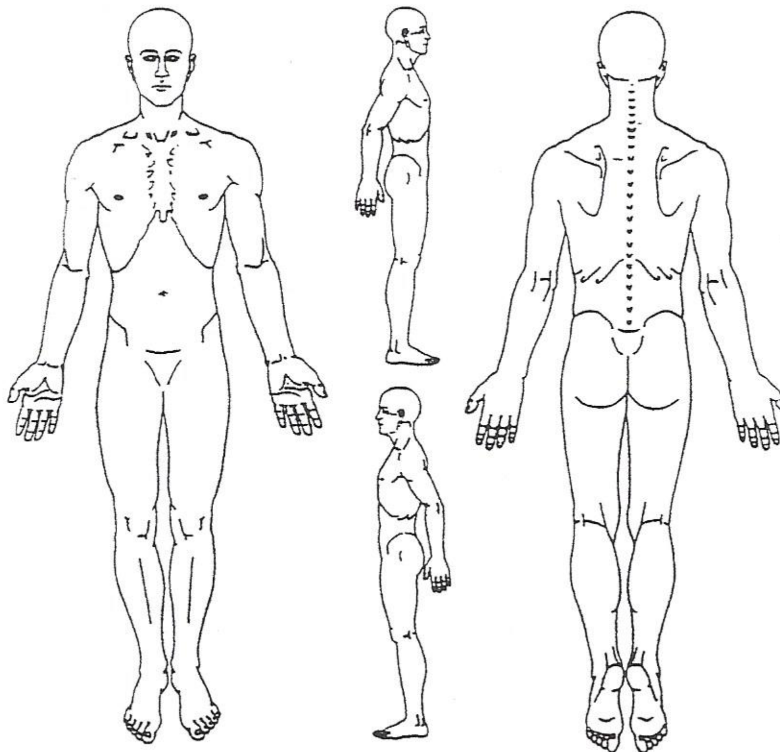
What is the location of you pain?

____

____

____

On the drawing below, please shade in the areas in which you are having pain.



Does your pain travel? If so, check and circle where.

To buttock___R, L
To groin___R, L
Up spine___R, L
To head___R, L
Around eye___R, L
To calf___R,L
To shoulder___R, L

Down leg to the ankle___R, L
Down side of leg to knee___R, L
Down leg to toes___R, L
Down back of leg to knee___R, L
Down Back of leg to sole of foot___R, L
To shoulder blade___R, L
To hip___R, L

How would you describe your pain? Please circle all that apply. Next to each put where you feel this.

Aching___________
Burning__________
Cramping_________
Cutting__________
Other___________

Dull____________
Electrical_________
Gripping__________
Numbness_________

Pins & Needles_________
Sharp_______________
Shooting____________
Stabbing____________

On average, 0 being no pain and 10 being the worst pain, rate the severity of your pain and circle that number.

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its least: 0 1 2 3 4 5 6 7 8 9 10

Right now: 0 1 2 3 4 5 6 7 8 9 10

How long has the pain been present in this (these) area(s)?

How many: Day(s) __________
Week(s) _________
Month(s) ________
Year(s) __________

Did this pain begin following an event such as: Date of Event: ______________

Motor Vehicle Accident Injury at Work Fall Lifting Surgery Illness

Are you currently in litigation? Yes___ No___

Are you currently working? Yes___ No___

If no, when did you stop? _______ Why? ______________________

If yes, were and what position? ___________________________

Medical History

Surgical History:

Date Procedure

_____ ______________________________
_____ ______________________________
_____ ______________________________
_____ ______________________________
_____ ______________________________

Hospitalization(s):

_____ ______________________________
_____ ______________________________
_____ ______________________________
_____ ______________________________
_____ ______________________________

Please circle the tests you have undergone. Put approximate date and name of facility where performed.

X-ray __________
MRI scans _______
EMG __________

CT scan __________________
Bone scan _________________
others (please List) __________

Do you have any medical or psychiatric problems that you see a doctor for? __________
____
____
____

Do you have any allergies to food or medication? If yes, please list your reaction to that food/ medication. ______________________________
____
____

Social History:

Do you smoke? If yes, how many per day? ____________________
Do you drink alcohol? If yes, how much per day? ______________
Do you have any children? ___________________________
Current height________ Current weight ________

Current Medication: Please List

Name	Strength (mg/mcg)	How many	How often (ex. Twice a day)

Musculoskeletal: check all that apply
Leg cramps___ Joint pain___ Muscle cramps___
Joint swelling___ Joint stiffness___

Neurology: check all that apply
Headache___ Tingling/numbness___ Seizures___
Insomnia___ Memory loss___ Tremors___
Vertigo___ Weakness in arms___ Weakness in legs___

Opioid Management: check all that apply
Nausea/vomiting___ itching, rash___ Constipation___
Sedation___ Sweating___ Swelling___ Dry mouth___
Blurred vision___ headaches___ Hallucination, weird dreams___

General: check all that apply
Easily fatigues___ trouble sleeping___ coldness (feel cold when others are comfortable) ___ cold limbs (feet, hands) ___ easy bruising___

Cardiology: check all that apply
Dizziness___ Chest pain___ Irregular heartbeats___ shortness of breath___

Hematology: check all that apply
Abnormal bruising___ Abnormal bleeding___

Respiratory: check all that apply
Wheezing___ Cough___

Signature________________________________ Date_______________