



Dr. James Leiber, Dr. Michael Amoroso, Dr. Ron Torrance, and Dr. Ignatios Papas

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS		
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)				EMPLOYER PHONE
LANGUAGE	ETHNICITY				RACE
EMAIL ADDRESS					
INSURED/RESPONSIBLE PARTY INFORMATION			RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE		EMPLOYER
● PRIMARY INSURANCE INFORMATION *Please provide card at the time of your appointment*					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
ID/MEMBER NUMBER	GROUP NUMBER	EMPLOYER		EMPLOYER PHONE	
● SECONDARY INSURANCE INFORMATION *Please provide card at the time of your appointment*					
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP		PHONE NUMBER
PREFERRED PHARMACY			PHARMACY LOCATION		PHARMACY PHONE
<b>ASSIGNMENT AND RELEASE:</b> I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.					
<b>Signature</b> of Patient or, if minor Signature of parent or guardian confirming all information is truth to the best of your knowledge, received PHI and signed consent					
X					
<b>RELEASE OF INFORMATION</b>					
I understand that my records are protected and cannot be disclosed without written permission. I understand that this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.					
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT			SIGNATURE OF WITNESS (Optional):		

2401 University Parkway | Suite 104 | Sarasota, FL 34243  
 Phone: 941-357-1773 Fax: 941-256-7452

8600 Hidden River Parkway Suite 700 Tampa, FL 33637  
 Phone: 813-544-3123 Fax: 941-256-7452



### Authorization for Use or Disclosure of Protected Health Information (PHI)

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called **PHI, Protected Health Information**, under a federal health privacy law, as described below.

I, \_\_\_\_\_, authorize New ReGeneration Orthopedics of FL, PLLC to release and obtain my private health information to/from (check all that applies):

- My spouse/partner
- My primary care physician/staff
- My pharmacy
- My parent/child(ren)
- My personal representative
- Other
  
- None of the above

Name of spouse/partner: \_\_\_\_\_  
 Name of physician: \_\_\_\_\_  
 Name of pharmacy: \_\_\_\_\_  
 Name(s): \_\_\_\_\_  
 Name of representative: \_\_\_\_\_  
 Name: \_\_\_\_\_

May our office leave a message on your machine?  Yes  No

Are there any restrictions on PHI to be disclosed?  Yes  No

If yes, please describe:

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The PHI will be disclosed to confirm appointments, to render to caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Regenexx Tampa Bay. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at 2401 University Parkway, Suite 104, Sarasota 34243*. I understand that my revocation will not affect any actions taken by prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release this protected health information expires.

\_\_\_\_\_  
Patient Signature or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed



## Patient General Consent to Treatment

I, the undersigned hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medication
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

**Medicare Patients:** I authorize **Regenexx Tampa Bay** to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **Regenexx Tampa Bay**.

I acknowledge that I have been notified of New ReGeneration Orthopedics of Fl. PLLC Privacy Practices and understand that if I have a question or complain that I should contact the Privacy Official. (**Patient Initials**\_\_\_\_\_).

I, the undersigned, authorize New ReGeneration Orthopedics of Fl. PLLC to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
Date



**Request Release of Medical Records to Regenexx Tampa Bay**

2401 University Parkway, Suite 104, Sarasota, FL 34243 Phone: 941-357-1773 Fax: 941-256-7452  
8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 Phone: 813-544-3123 Fax: 941-256-7452

To (Providing Facility/Location): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
SSN

**I Request That Records Be Released That Pertain to The Following Body Region(s):**

\_\_\_\_\_

**Specifically, I Request for The Following to Be Sent:**

- X-Rays (Radiology Report and Imaging Disk)
- Mri's (Radiology Report and Imaging Disk)
- Consult Reports
- Operative Reports
- Complete Records
- Other \_\_\_\_\_

**Please Release to:**

- 2401 University Parkway, Suite 104, Sarasota, FL 34243 - Phone: 941-357-1773 - **Fax: 941-256-7452**
- 8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 - Phone: 813-544-3123 - **Fax: 941-256-7452**

**Requesting Provider:**

- James Leiber, D.O.
- Ronald Torrance, D.O.
- Ignatios Papas, D.O.
- Michael Amoroso, M.D.

I authorize your facility to release the medical records requested by Regenexx Tampa Bay.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice.

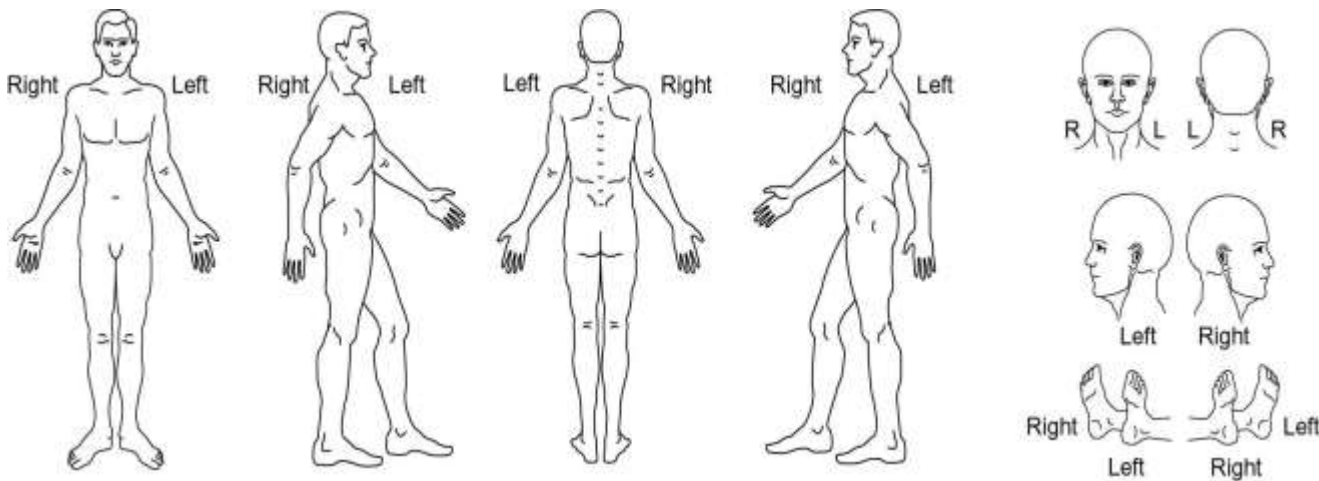
I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice.

## MUSCULOSKELETAL NEW PATIENT HISTORY FORM

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

- 1) REFERRED BY: \_\_\_\_\_
- 2) PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Last Visit: \_\_\_\_\_
- 3) DO YOU SEE A PAIN MANAGEMENT PHYSICIAN:  Yes  No  
 NAME: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_
- 4) REASON FOR THIS VISIT:  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE MARK THE AREAS ON THE DIAGRAM WHERE YOU ARE EXPERIENCING DIFFICULTY:



- 5) IS THIS THE RESULT OF AN INJURY OR ACCIDENT? IS THIS A WORKER'S COMPENSATION OR AUTOMOBILE INSURANCE RELATED CASE? (if Yes, please provide background information)  
 \_\_\_\_\_  
 \_\_\_\_\_

6) PRIMARY AREA YOU WOULD LIKE TO DISCUSS TODAY: **(please check one)**

- Neck/Upper back       Mid-back /Lower Back       Shoulder  
 Elbow       Wrist       Hand  
 Hip       Knee       Ankle       Foot

Comments: \_\_\_\_\_

7) THE FOLLOWING QUESTIONS PERTAIN TO THE PRIMARY AREA YOU'VE INDICATED IN QUESTION 4 ABOVE:

a) When and how did this problem **start**? \_\_\_\_\_  
 \_\_\_\_\_

b) How would you describe the **character** of your pain or complaint (check all that apply):

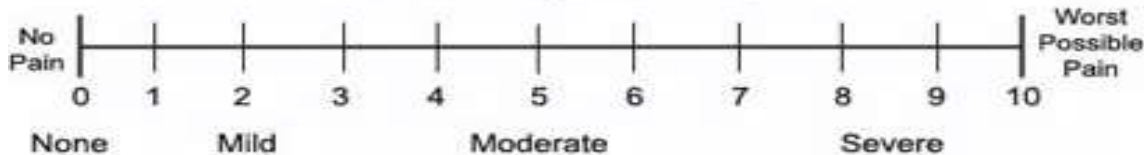
- Aching     Tightness/Stiffness     Numbness/Tingling     Cramping     Stabbing     Sharp     Shooting  
 Pressure     Burning     Weakness

If your chief complaint today is for knee pain, then please check the following (if they apply):

- Knee Popping     Knee Clicking     Knee Catching     Knee Instability

c) Does this pain/complaint **radiate** to any other locations? (if yes, describe the pattern) \_\_\_\_\_

d) How severe is the pain/complaint **currently** on a scale of 0 (no pain) to 10 (worst possible pain)? [please circle the appropriate number on the scale below]



Comments: \_\_\_\_\_

What is the pain **on average** throughout the day on a scale of 0 – 10? \_\_\_\_\_

e) Is this pain/complaint **constant**?  Yes  No

i) **How much of the day** is your discomfort or pain present?

Less than 1 hour  4 hours  6 hours  12 hours  18 hours  24 hours

f) How has this pain/complaint **changed over time**?  getting better  getting worse  no change

g) What makes this pain/complaint **worse**? \_\_\_\_\_

i) Does it get worse with bending the area? (For neck or low back pain, is it worse with bending forward, backwards, or with turning?) \_\_\_\_\_

ii) Does it get worse with sneezing or coughing?  Yes  No

h) What makes this pain/complaint **better**? \_\_\_\_\_

i) Is it better at certain times of day? \_\_\_\_\_

ii) Is it better with  rest or  motion? Are there certain positions that ease the problem? \_\_\_\_\_

**8) FUNCTIONAL LIMITATIONS AND GOALS**

a) What **activities** is this pain/complaint affecting? \_\_\_\_\_

b) What are your **goals** for treatment? \_\_\_\_\_

**9) PRIOR TREATMENT**

a) Have you taken any **Medications/Botanical Herbs/Supplements** for this problem? Please indicate below:

<u>Name</u>	<u>Dose</u>	<u>Length of Time Taken</u>	<u>Helpful</u> (Not at all/Mildly/ Moderately/Very)

b) Have you had **Physical Therapy** for this problem?  Yes  No When? \_\_\_\_\_

For how long? \_\_\_\_\_ Was this helpful? \_\_\_\_\_

c) Have you had **Manual Adjustments** (e.g Chiropractic or Osteopathic) for this problem?

Yes  No When? \_\_\_\_\_

For how long? \_\_\_\_\_ Was this helpful? \_\_\_\_\_

d) Have you had **Acupuncture** for this problem?  Yes  No When? \_\_\_\_\_

For how long? \_\_\_\_\_ Was this helpful? \_\_\_\_\_

e) Have you had **Massage** for this problem?  Yes  No When? \_\_\_\_\_

For how long? \_\_\_\_\_ Was this helpful? \_\_\_\_\_

**PRIOR TREATMENT (CONTINUED)**

- f) Have you had any **Injections** for this problem?  Yes  No When? \_\_\_\_\_  
What kind? \_\_\_\_\_  
For how long/How many times? \_\_\_\_\_  
Was this helpful? \_\_\_\_\_ If so, for how long? \_\_\_\_\_
- g) Have you had any **other treatment interventions** for this problem?  Yes  No  
When? \_\_\_\_\_ For how long/How many times? \_\_\_\_\_  
Was this helpful? \_\_\_\_\_

**What other consultations have you had regarding this problem?**

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**10) HAVE YOU RECEIVED ANY SPECIAL TESTING OR PROCEDURES FOR THIS PROBLEM?**

**(PLEASE BRING COPIES OF REPORTS OR HAVE SENT TO US)**

<u>TEST</u>	<u>DATE</u>	<u>LOCATION</u>	<u>RESULTS (in your own words is ok)</u>
XRAY	_____	_____	_____
CAT SCAN (CT)	_____	_____	_____
MRI	_____	_____	_____
ULTRASOUND	_____	_____	_____
EMG/NERVE CONDUCTION	_____	_____	_____
OTHER (please specify)	_____	_____	_____

**11) OTHER**

- a. **ARE YOU CURRENTLY ON ANY BLOOD THINNERS**?  Yes  No
- b. **ARE YOU CURRENTLY ON ANY ONGOING STEROID THERAPY**?  Yes  No
- c. **WHAT IS YOUR CURRENT LEVEL OF STRESS**?  none  mild  moderate  severe
- d. Have you ever taken **quinolone antibiotics** (Cipro, Levofloxin)?  Yes  No, If so, when? \_\_\_\_\_
- e. Have you ever had **elevated calcium levels**?  Yes  No If yes, then when? \_\_\_\_\_  
Do you recall the level? How can we obtain this result? \_\_\_\_\_
- f. **Do you have a history of nausea/vomiting with pain medication?**  Yes  No  Unknown
- g. **Have you had any adverse reactions to local anesthetics (e.g. novicaine)?**  No  Yes  
**If yes, What was your reaction?** \_\_\_\_\_
- h. **Does it take longer for you to get numb at the dentist?**  Yes  No  Unsure
- i. Have you ever been in a motor vehicle accident or any other kind of accident?  Yes  No  
If so: What injuries did you sustain? Do you feel that it is contributing to your current problem for which you are being evaluated today? \_\_\_\_\_

<b>For FEMALES ONLY:</b>		
When was your last <b>menstrual period</b> ? _____	<b>Yes</b>	<b>No</b>
Have you had laboratory tests to check your <b>hormone levels</b> (estrogen, progesterone, testosterone, DHEA)?		
Have you had laboratory tests to check your <b>thyroid levels</b> ?		
Are you on any <b>hormone replacement therapy</b> (estrogen, progesterone, testosterone, DHEA, thyroid)? _____		
Have you had laboratory tests to check your <b>Vitamin D levels</b> ?		

<b>For MALES ONLY:</b>
<ul style="list-style-type: none"> <li>Do you have any of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> low sex drive</li> <li><input type="checkbox"/> erectile dysfunction/difficulties</li> <li><input type="checkbox"/> mood problems</li> <li><input type="checkbox"/> fatigue or low energy</li> <li><input type="checkbox"/> sleep disturbances/difficulties</li> </ul> </li> </ul>
Have you had your <b>Testosterone blood levels</b> checked? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had laboratory tests to check your <b>Vitamin D levels</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No

**REVIEW OF SYSTEMS/SYMPTOMS**

**(Check any symptoms or findings that you have experienced recently)**

<b>CONSTITUTIONAL</b>	<input type="checkbox"/> weight change <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> general weakness
<b>EYES</b>	<input type="checkbox"/> vision problems <input type="checkbox"/> double vision <input type="checkbox"/> yellowing of the eyes
<b>ENT</b>	<input type="checkbox"/> hearing problems <input type="checkbox"/> dizziness <input type="checkbox"/> sinus trouble <input type="checkbox"/> sore throat <input type="checkbox"/> ringing ears <input type="checkbox"/> bleeding gums <input type="checkbox"/> periodontal disease
<b>CARDIOVASC</b>	<input type="checkbox"/> shortness of breath <input type="checkbox"/> chest pain <input type="checkbox"/> leg swelling <input type="checkbox"/> increased blood pressure
<b>RESPIRATORY</b>	<input type="checkbox"/> cough <input type="checkbox"/> coughing up blood <input type="checkbox"/> wheezing <input type="checkbox"/> asthma <input type="checkbox"/> other difficulty breathing <input type="checkbox"/> snoring <input type="checkbox"/> gasping for air during sleep <input type="checkbox"/> fall asleep during the day
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> trouble swallowing <input type="checkbox"/> heartburn <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> blood or black tarry stools <input type="checkbox"/> abdominal pain <input type="checkbox"/> gas <input type="checkbox"/> bloating
<b>GENITOURINARY</b>	<input type="checkbox"/> pain with urination, blood in urine <input type="checkbox"/> urgency <input type="checkbox"/> incontinence <input type="checkbox"/> increased urination <input type="checkbox"/> impotence/erectile dysfunction (for males) <input type="checkbox"/> prostate problems (males)
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> joint pain <input type="checkbox"/> joint stiffness <input type="checkbox"/> muscle cramps <input type="checkbox"/> muscle twitching <input type="checkbox"/> muscle weakness <input type="checkbox"/> loss of motion <input type="checkbox"/> tendonitis <input type="checkbox"/> swelling of finger or other joints <input type="checkbox"/> redness of joints
<b>SKIN/HAIR/NAILS</b>	<input type="checkbox"/> rash <input type="checkbox"/> lumps/masses <input type="checkbox"/> itchy <input type="checkbox"/> dryness <input type="checkbox"/> hair changes <input type="checkbox"/> nail changes <input type="checkbox"/> yellowing of skin
<b>NEUROLOGICAL</b>	<input type="checkbox"/> fainting <input type="checkbox"/> blackouts <input type="checkbox"/> seizures <input type="checkbox"/> paralysis <input type="checkbox"/> weakness <input type="checkbox"/> numbness <input type="checkbox"/> memory loss <input type="checkbox"/> numbness in a saddle distribution (inner legs and groin) <input type="checkbox"/> headaches <input type="checkbox"/> tremors
<b>PSYCHOLOGICAL</b>	<input type="checkbox"/> nervousness <input type="checkbox"/> tension <input type="checkbox"/> mood changes <input type="checkbox"/> depression <input type="checkbox"/> anxiety
<b>ENDOCRINE</b>	<input type="checkbox"/> decreased libido <input type="checkbox"/> heat or cold intolerance <input type="checkbox"/> excessive thirst <input type="checkbox"/> increased hunger <input type="checkbox"/> increased craving for sweets or carbs <input type="checkbox"/> low blood pressure <input type="checkbox"/> hot flashes
<b>HEMATOLOGY/ONCOLOGY</b>	<input type="checkbox"/> easy bruising <input type="checkbox"/> bleeding (difficulty clotting) <input type="checkbox"/> venous thrombosis (clots) <input type="checkbox"/> current or history of cancer



## PAST MEDICAL HISTORY

**CHECK ALL THAT APPLY:**

**Chronic Musculoskeletal Pain:**

- |                                     |                                   |                                     |                                       |
|-------------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Neck     | <input type="checkbox"/> Hip        | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Elbow      | <input type="checkbox"/> Mid-back | <input type="checkbox"/> Knee       |                                       |
| <input type="checkbox"/> Wrist/hand | <input type="checkbox"/> Low back | <input type="checkbox"/> Ankle/foot |                                       |

**Other Medical History:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Abuse:                                 | <input type="checkbox"/> Physical                                  | <input type="checkbox"/> Emotional                         | <input type="checkbox"/> Sexual (Treatment: _____) |
| <input type="checkbox"/> Abnormal Heart Rhythm                  | <input type="checkbox"/> Fibroids                                  | <input type="checkbox"/> Lupus                             |  |
| <input type="checkbox"/> Anemia                                 | <input type="checkbox"/> Fibromyalgia                              | <input type="checkbox"/> Lyme disease                      |  |
| <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Food allergies or intolerances            | <input type="checkbox"/> Osteoarthritis                    |  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Headaches/Migraines                       | <input type="checkbox"/> Osteoporosis                      |  |
| <input type="checkbox"/> Autoimmune Disease                     | <input type="checkbox"/> Heart Attack                              | <input type="checkbox"/> Parkinson's Disease               |  |
| <input type="checkbox"/> Bipolar Disorder                       | <input type="checkbox"/> Heart Disease                             | <input type="checkbox"/> Premenstrual Syndrome             |  |
| <input type="checkbox"/> Bowel or Bladder Incontinence          | <input type="checkbox"/> High Blood Pressure                       | <input type="checkbox"/> Prostatitis                       |  |
| <input type="checkbox"/> Broken Bones _____                     | <input type="checkbox"/> High Cholesterol                          | <input type="checkbox"/> Pulmonary Embolism (clot in lung) |  |
| <input type="checkbox"/> Cancer (what kind/when? _____)         | <input type="checkbox"/> Psoriasis                                 |  |  |
| <input type="checkbox"/> Crohn's Disease                        | <input type="checkbox"/> Hepatitis                                 | <input type="checkbox"/> Rheumatoid Arthritis              |  |
| <input type="checkbox"/> Deep Vein Thrombosis (clot)            | <input type="checkbox"/> HIV/AIDS                                  | <input type="checkbox"/> Seizures                          |  |
| <input type="checkbox"/> Dementia                               | <input type="checkbox"/> Impotence                                 | <input type="checkbox"/> Sleep Apnea                       |  |
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Infertility                               | <input type="checkbox"/> Stomach Ulcers                    |  |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Insulin resistance or Borderline Diabetes | <input type="checkbox"/> Stroke                            |  |
| <input type="checkbox"/> Emphysema or Chronic Bronchitis (COPD) | <input type="checkbox"/> Irritable Bowel Syndrome                  | <input type="checkbox"/> Thyroid Disease                   |  |
| <input type="checkbox"/> Endometriosis                          | <input type="checkbox"/> Insomnia or other Sleep disturbance       | <input type="checkbox"/> Ulcerative Colitis                |  |
| <input type="checkbox"/> Other _____                            |  |  |  |

## SURGICAL HISTORY/HOSPITALIZATIONS

_____	Date: _____
_____	Date: _____
_____	Date: _____

## SOCIAL HISTORY

What is your **Marital Status**?

Single  Married  Divorced  Widowed  Gay/Lesbian  Long term partnership  Bisexual  Transgender

What is your **Occupation** (if retired, from what occupation are you retired)?

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Do you use **Tobacco** (smoke or chew)?  Yes  No If yes, then how much and for how long?

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If no, then do you have a history of tobacco use?  Yes  No

If yes, then for many years did you smoke? \_\_\_\_\_ How long ago did you quit? \_\_\_\_\_

Do you use **Alcohol**?  Yes  No If yes, then how often and how much?

---

Do you use **Drugs**?  Yes  No If yes, then how often and how much?

---

Do you currently follow a **Specific Diet or Nutritional program**?  Yes  No

---

Do you **Cook**?  Yes  No

Do you **Grocery Shop**?  Yes  No

Do you **Read Food Labels**?  Yes  No

How many **Servings of Fruits/Vegetables** do you have per day (do not include fruit juice, potatoes, or processed foods)?

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How many times per week do you **Eat Out** (include: breakfast, lunch, dinner, and dessert/snacks)?

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Do you **Exercise**?  Yes  No What type and How often?

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What are your **Hobbies/Interests**? \_\_\_\_\_

Do you currently have or have you had any **Environmental Exposures** to chemicals/toxins/radiation?

---

Are you **sensitive to any Environmental Chemicals** (e.g. perfumes/colognes, auto exhaust, MSG, etc)?

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## FAMILY HISTORY

Father:  alive; age \_\_\_\_\_  deceased; age \_\_\_\_\_ Medical problems \_\_\_\_\_

\_\_\_\_\_

Mother:  alive; age \_\_\_\_\_  deceased; age \_\_\_\_\_ Medical problems \_\_\_\_\_

\_\_\_\_\_

Brothers: Medical problems \_\_\_\_\_

Sisters: Medical problems \_\_\_\_\_

Other medical problems that run in the family?  Diabetes  Heart Problems  Cancer  Thyroid problems   
Osteoarthritis  Autoimmune Diseases (for example: Rheumatoid Arthritis, Lupus, Crohn's Disease, etc.)

## ALLERGIES (to medications)

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Add additional allergies on the back of this form or attach to the paperwork

## MEDICATIONS/BOTANICAL HERBS/SUPPLEMENTS LIST

NAME

DOSAGE

HOW OFTEN TAKEN

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_