New Jersey Regenerative Institute, LLC

Name: _____ Sex:_____ Age:_____

Handedness: Right or Left Date of Birth: _____

Referral source: Self Website Physician (specify): _____

Primary Care Physician (PCP):_____

Reason for visit?: _____

Complaints/Symptoms: _____

Precipitating Event: _____

Date of Onset: _____

Pain Intensity (0-10 scale) - Average pain: (0- no pain, 10 worst)_____

What makes your pain worse: _____

What makes your pain better: _____

Other symptoms (weakness, numbness, tingling, etc.)_____

Previous Tests (X-rays, CT scans, MRI's, Bone scans, EMG). Please give approximate dates and results if known.

_____

_____

_____

_____

_____

_____

Prior Treatments:

Medications: _____
_____
Any relief?_____
Therapy (PT?OT? etc.):_____
Any improvement?_____
Bracing:_____
Procedures (injections, surgery):_____
Any improvement?_____

[Continued on next page]

Medical History (circle):

High Blood Pressure | Diabetes Mellitus | Cardiac Disease (Type:_____)

Peripheral Vascular Disease | Stomach Ulcers | Depression/Anxiety | Psychiatric

Thyroid Disease | Cancers Type:_____ | Stroke | Osteoporosis

Joint Disease (Rheumatoid, osteoarthritis, etc.) | Asthma | Substance Abuse Drug:_____

Other: _____

Surgical History:

_____Appendix
_____Gall Bladder
_____Neck or Back surgery (specify)_____
_____Carpal Tunnel Release
_____Joint replacements/repairs (specify)_____
_____Other/please specify:_____

Medications (Please List All the **Pills** You are Taking):

Anti-inflammatories (specify) _____
Opioid (specify) _____
Tricyclics (specify) _____
Anticonvulsants (specify):_____
Vitamins/Supplements: _____
Other: _____

Allergies/Intolerances to Medications: _____

Social History:

_Yes_No__Alcohol How much caffeine do you consume? (coffee, tea, soda, etc.)____Cups
_Yes_No__Smoke (Did you ever smoke, if so when did you quit?)_____
_Yes_No__Non-prescription Drugs (marijuanna, cocaine, vitamins, herbs, etc.)_____
Occupation:_____ or on Disability (for how long)_____
Marital status (circle): single married divorced separated
Children: _____

Family History (circle):

High Blood Pressure | Diabetes Mellitus | Cardiac Disease

Peripheral Vascular Disease | Stomach Ulcers | Stroke

Thyroid Disease | Cancers Type:_____ | Psychiatric (Anxiety/Depression/Etc.)

Joint Disease (Rheumatoid, Osteoarthitis, Connective tissue disease) Osteoporosis

Functional History (circle):

Activities of Normal Daily Life: Independent Need Assistance Dependent on Help
Difficulty walking Yes No Difficulty Sleeping Yes No
Transfers Problems Yes No
Equipment (ie cane, walker, tub bench, etc.)_____

Do you exercise routinely (circle): Yes No
Type of Exercise: _____ How Frequent?: _____

[Continued on next page]

Review of Systems- Do you have any of the following:

- Constitutional

Generally Good Health	Yes	No
Recent Weight Change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

- Eyes

Eye disease or Injury	Yes	No
Wear Glasses/Contact Lenses	Yes	No
Blurred Vision/Double Vision	Yes	No
Glaucoma	Yes	No

- Ears/Nose/Throat

Hearing Loss or Ringing	Yes	No
Chronic Sinus Problems/Rhinitis	Yes	No
Nose Bleeds	Yes	No
Mouth Sores	Yes	No
Bleeding Gums	Yes	No
Bad Breath or Bad Taste	Yes	No
Sore Throat or Voice Change	Yes	No
Swollen Glands in Neck	Yes	No

- Cardiovascular

Heart Trouble	Yes	No
Chest Pain or Angina	Yes	No
Palpitations	Yes	No
Shortness of Breath w/Walking	Yes	No
Shortness of Breath w/Lying Flat	Yes	No
Swelling of Feet/Ankles/Hands	Yes	No

- Respiratory

Chronic of Frequent Coughs	Yes	No
Spitting Up Blood	Yes	No
Shortness of Breath	Yes	No
Asthma or Wheezing	Yes	No

- Gastrointestinal

Loss of Appetite	Yes	No
Change in Bowel Movements	Yes	No
Nausea or Vomiting	Yes	No
Frequent Diarrhea	Yes	No
Painful Bowel Movements	Yes	No
Constipation	Yes	No
Rectal Bleeding	Yes	No
Abdominal Pain or Heartburn	Yes	No
Stomach Ulcer	Yes	No

- Genitourinary

Frequent Urination	Yes	No
Burning or Painful Urination	Yes	No
Blood in Urine	Yes	No
Change in Force or Straining w/Urinating	Yes	No
Incontinence or Dribbling	Yes	No
Kidney Stones	Yes	No
Sexual Difficulty	Yes	No
Male- Testicle Pain	Yes	No
Female- Pain w/Periods	Yes	No
Female- Irregular Periods	Yes	No
Female- Vaginal Discharge	Yes	No

Female #Pregnancies___ #Miscarriages___
Female- Date of Last Pap Smear_____

- Musculoskeletal

Joint Pain	Yes	No
Joint Stiffness or Swelling	Yes	No
Weakness of Muscles or Joints	Yes	No
Muscle Pain or Cramps	Yes	No
Back Pain	Yes	No
Cold Extremities	Yes	No
Difficulty Walking	Yes	No

- Integumentary

Rash or Itching	Yes	No
Change in Skin Color	Yes	No
Change in Hair or Nails	Yes	No
Varicose Veins	Yes	No
Breast Pain	Yes	No
Breast Lump	Yes	No
Breast Discharge	Yes	No

- Neurologic

Frequent or Recurrent Headaches	Yes	No
Lightheaded or Dizzy	Yes	No
Convulsions or Seizures	Yes	No
Numbness/Tingling Sensations	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head Injury	Yes	No

- Psychiatric

Memory Loss or Confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

- Endocrine

Glandular or Hormone Problems	Yes	No
Thyroid Disease	Yes	No
Diabetes	Yes	No
Excessive Thirst or Urination	Yes	No
Heat or Cold Intolerance	Yes	No
Skin becoming Dryer	Yes	No
Change in Hat/Glove Size	Yes	No

- Hematologic/Lymphatic

Slow to Heal after Cuts	Yes	No
Bleeding or Bruising Tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past Blood Transfusion	Yes	No
Enlarged Glands	Yes	No

Doctor Reviewed: _____
Date

[Continued on next page]

NAME:_____ DATE:_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
Δ Δ Δ Δ	= = = = =	O O O O O	XX X X	/ / / / /	. . . . .