DENVER REGENERATIVE MEDICINE

1. **Please enter your information:**

First Name: _____ Last Name: _____ Date of Birth: _____ Email: _____

Address: _____

Mobile Phone: _____ Home Phone: _____ Preferred Contact: ○ Email ○ Phone Gender: ○ Female ○ Male

2. **Who is your primary care physician?**

Physician Name: _____ Physician Phone: _____ Physician Email: _____

Address: _____

3. **What specific conditions are you affected by (if any)?**

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Erectile Dysfunction
☐ COPD ☐ Multiple Sclerosis ☐ Type 2 Diabetes
☐ Parkinson's Disease ☐ Hair Loss ☐ Other:

4. **What area(s) of your body are affected by your condition (if any)?**

☐ Shoulders ☐ Elbows ☐ Hands & Wrists
☐ Knees ☐ Feet & Ankles ☐ Hips & Pelvis
☐ Upper Back ☐ Lower Back ☐ Other:

5. How often are you in pain? ○ Never ○ Occasionally ○ Always
Does anything increase pain? ○ Yes ○ No
Does anything reduce pain? ○ Yes ○ No

6. **Does the pain prohibit you from enjoying activities? (e.g. can't run due to knee pain)**

_____
_____
_____
_____

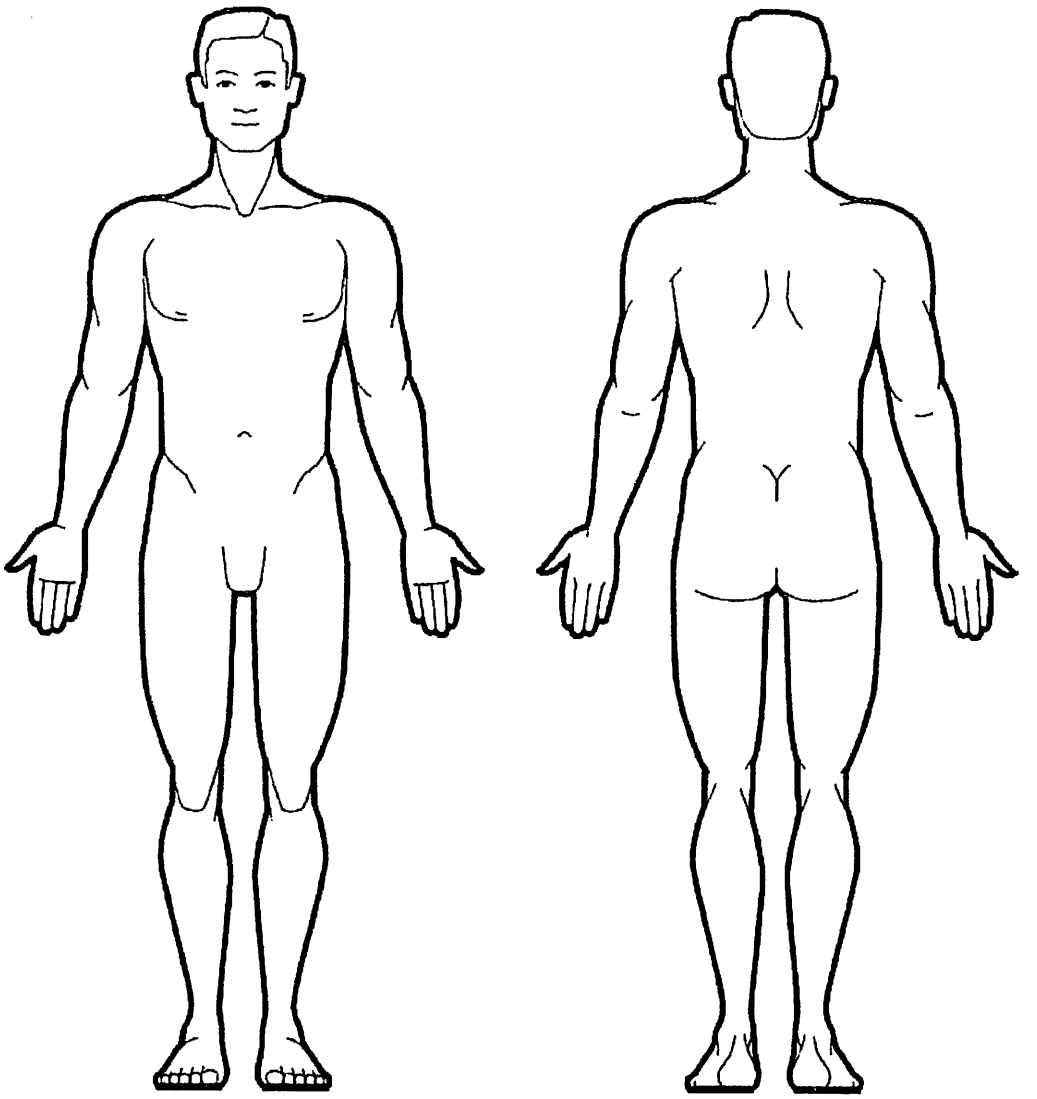
7. **Please list all known allergies (especially to medication):**

	Allergen
1	
2	
3	

8. **Please list all medications (including non-prescription):**

	Medication
1	
2	
3	
4	
5	

9. Please mark all affected areas of your body using the color-coded symbols.



10. **The following treatments may have a positive, negative, or no effect at all. Please mark the item(s) which apply to you, including those in which you currently use (disregard if not applicable).**

	Increases	Decreases	No Effect
Medications			
Stretching			
Mild Exercise			
Physical Therapy			
Stress / Tension			
Standing			
Driving			
Sitting			
Walking			
Bending			
Lifting			
Reaching			
Other:			

11. **Please list all medical conditions (if any):**

- ☐ No Problems
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Abnormal Rhythm
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Stomach Ulcers
- ☐ Irritable Bowel
- ☐ HIV / AIDS
- ☐ Stroke
- ☐ Seizures
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Blod Clots
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Anorexia / Bulemia
- ☐ Alcoholism
- ☐ Psyciatric Disorder
- ☐ Cancer:

12. **Please list all previous surgeries (if any):**

☐ Neck	☐ Brain	☐ Prostate
☐ Shoulder	☐ Lung	☐ Thyroid
☐ Back	☐ Heart	☐ Appendix
☐ Elbow	☐ Liver	☐ Gallbladder
☐ Spine	☐ Kidney	☐ Hernia
☐ Wrist	☐ Spleen	☐ Cataract
☐ Pelvis	☐ Stomach	☐ C-Section
☐ Hand	☐ Pancreas	☐ Replacement
☐ Hip	☐ Bladder	☐ Arterial Stent
☐ Knee	☐ Eye	☐ Hysterectomy
☐ Ankle	☐ Ear	☐ Disk Fusion
☐ Foot	☐ Breast	☐ ACL/MCL

13. **The following treatments listed below may have a positive, negative, or no effect at all. Please mark the item(s) which apply to you, including those in which you currently use (disregard if not applicable).**

	Currently Using	Makes Better	Makes Worse	No Effect
Physical Therapy				
Pool Therapy				
Massage Therapy				
Chiropractor				
Exercise				
Tens Unit				
Injections				
Acupuncture				
Splints / Braces				
Foot Cushions				
Carpal Tunnel Op.				
Arthroscopic Op.				

Patient Signature:

_____ _____

Signature Date

14. **Thank you for taking the time to complete your intake paperwork online.**

Visual Analogue Scale

Please, mark with an "x", on the line below where you feel your pain is on the scale, for each location.

(example: ----------x----------)

Location:

No Pain ---------- *Worst pain ever*

Location:

No Pain ---------- *Worst pain ever*

Location:

No Pain ---------- *Worst pain ever*

Location:

No Pain ---------- *Worst pain ever*