Regenexx®

MUSCULOSKELETAL NEW PATIENT HISTORY

Patient Name_____Age:_____DOB:_____Hand Dominance: ☐ Right ☐ Left

Chief Complaint:_____

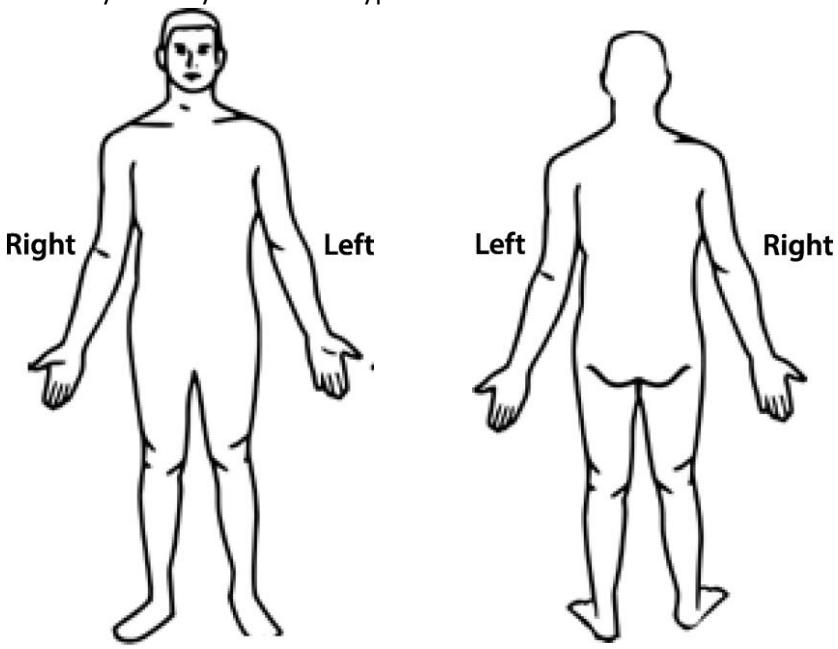
Date of Injury: _____

When and how did this problem occur: _____

Use the symbols below to mark areas on the body where you feel that type of sensation:

KEY:

= = =	**numbness**
^ ^ ^	**ache**
000	**pins and needles**
/ / /	**stabbing**
XXX	**burning**
- - -	**shooting**
* * *	**tingling**



FRONT **BACK**

Pain Rating Scale

Please make an "X" on the line below that corresponds to the area of your body that you feel pain and its severity. Rate how much your pain hurts on an average day by placing the "X" along the line from "NO PAIN" on the left to "WORST PAIN I CAN POSSIBLY IMAGINE" on the right.

	NO PAIN										WORST PAIN I CAN POSSIBLY IMAGINE
Back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg Pain	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	0	1	2	3	4	5	6	7	8	9	10

When do you experience pain? _____

What makes your pain worse? _____

What makes your pain better? _____

What daily activities does this problem affect? _____

Have you received any of the following for this problem? ☐ CT Scan ☐ MRI ☐ EMG ☐ X-Rays ☐ Injections ☐ Surgeries

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Review of Systems: Circle any of the symptoms below that you've experienced recently
Constitutional: weight change, weakness, fatigue, fever, nausea
ENMT: hearing problems, dizziness, sinus trouble, sore throat, ringing ears
Eyes: vision problems, double vision
Respiratory: cough, coughing up blood, wheezing, asthma
Cardiovascular: shortness of breath, chest pain, leg swelling, increased blood pressure
Gastrointestinal: trouble swallowing, heartburn, vomiting, diarrhea, blood or black tar stools
Genitourinary: pain with urination, blood in urine, urgency, incontinence
Musculoskeletal: join pain/stiffness, cramps, weakness, loss of motion
Skin: rash, lumps, itching, dryness, hair changes, nail changes
Neurological: fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss, headaches
Psychological: nervousness, tension, mood changes, depression, anxiety
Endocrine: heat or cold intolerance, sweating, thirst, changes with hunger
Hematology: bruising, bleeding, transfusion reactions

Past Medical History

Allergies: List all medication/food/chemical allergies ☐ No Allergies

_____

_____

Prescription Medications: ☐ None

_____

_____

Over The Counter Medications/Supplements/Vitamins/Creams/Eye Drops/Oils/Etc. ☐ None

_____

Medical Illnesses: Check those you have been diagnosed with ☐ None
☐Diabetes ☐Asthma ☐High Blood Pressure ☐Heart Attack ☐Sleep Disorders ☐Stroke ☐Stomach Ulcers ☐Cancer ☐Heart Murmur ☐HIV/AIDS ☐Hepatitis ☐Anemia ☐Seizures ☐Hyper/Hypo Thyroid ☐Osteoporosis ☐Deep Vein Thrombosis ☐Broken Bones ☐Bowel or Bladder Incontinence ☐Gout ☐Osteoarthritis or Rheumatoid Arthritis
☐Other: _____

Injuries: Please include broken bones, concussion, motor vehicle accidents, falls, etc. ☐ No Injuries

_____

_____

Surgeries: Please include dates ☐ No Surgeries

_____

_____

Family History: Check those that apply ☐ No family history of medical problems
☐Arthritis ☐Back Problems ☐Heart Problems ☐Diabetes ☐Cancer ☐Other:_____

Social History:
Do you exercise: ☐Yes ☐No If yes, what type of exercise?_____
Occupation: _____
Hobbies/Interests:_____
Do you use tobacco? ☐Yes ☐No If yes, how often?_____
Do you use alcohol? ☐Yes ☐No If yes, how often? _____
Do you use drugs? ☐Yes ☐No If yes, how often? _____