HEALTH & HOPE INSTITUTE

Allow Nature and your Heart to guide your Healing Journey

MEDICAL RECORD-NEW PATIENT INTAKE FORM

Date _____ Last Name_____ First Name _____ Middle _____

Date of birth_____ Age_____ Height _____ Weight_____ SS#_____

ADDRES (Street, City, State, Zip Code)_____

Cell Phone _____ Other Phone _____Email _____

Emergency Contact Name and Phone

_____

Name of Doctor or Patient who referred you to us _____Doctor's Diagnosis_____

Ages of Children ___ Religion (optional) _____Marital Status _____Occupation _____

ALLERGIES: Allergic to Fish, Iodine, Nuts or Shellfish? No __ Yes __, to what

_____

Any allergy or adverse reaction to a medication, anesthetic, food, chemical, supplement or vitamin. No __ Yes __ If Yes, **Agent/Medication/Food** **Type of Reaction**

_____ _____

_____ _____

_____ _____

PATIENT MEDICAL HISTORY

CHIEF COMPLAINT / REASON FOR APPOINTMENT_____

_____

_____

Severity of pain (from 1 to 10 with 10 being the worst) Average Pain ___ and How many days per week? _____

Pain average today _____ Worst Pain level ever _____ When _____ For how long? _____

PREVIOUS DIAGNOSES AND TEST RESULTS _____

_____

_____

PREVIOUS TREATMENTS AND RESULTS _____

_____

_____

HAS SURGERY BEEN RECOMMENDED? IF SO, WHAT KIND _____

HOW AND WHEN DID THE PROBLEM BEGIN?

_____

_____

WHAT MOTIONS OR ACTIVITIES MAKE THE PAIN <u>B</u>ETTER (B) OR <u>W</u>ORSE (W)?

B _____

W _____

ARE YOU CURRENTLY UNDER THE CARE OF OTHER DOCTOR/PRACTITIONERS?

Name _____ Treating what condition(s)? _____

_____

Name _____ Treating what condition(s)? _____

_____

HAVE YOU TAKEN STEROID OR NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS FOR THIS PROBLEM?

Drug(s) _____

For how long? _____When did you last had/take a dose?

_____

JOINTS / AREAS OF YOUR BODY WHERE YOU EXPERIENCE **ACUTE (A), <u>R</u>ECURRING (R), <u>C</u>HRONIC (C) SYMPTOMS**

Location and Type of Symptom A , <u>R,</u> or <u>C</u> Severity of Pain from 1 to 10 (10 being the worst possible pain)

_____ _____
_____ _____

ASSOCIATED WITH YOUR PROBLEM, DO YOU HAVE. (Pain, Numbness, Tingling, Aching, etc., going to other areas) If yes, describe. _____

_____

Muscle Tightness __, Spasms __, Trigger Points __, Muscle weakness __, numbness/tingling __ Radiating Pain to legs of Arms _____, Pain on Cervical Spine __, Thoracic spine __, Lumbo-Sacral region __, Limitation of Range of Motion_____

Headache, Ringing in Ears, Sinus problems, Visual Problems, Hearing Problems, other Head and Neck Symptoms_____

_____

Loose Joints, Unstable Joints, Cracking and Popping, Loss of Cartilage, Unusual Flexibility, History of Torn Meniscus or Labrum_____

_____

SLEEPING HABITS: Do you have trouble sleeping? _____Average Hours per Night? ____ Do you take a sleep aid? _ ____
Hours of uninterrupted sleep during an average night? _____ Reasons for awakening? _____
EATING HABITS: Your nutrition is EXCELLENT _____ AVERAGE _____ POOR____
You take supplements and vitamins? Yes ____ No ____ Have you seen a nutrition professional? Yes ___ No ____
LIFESTYLE: Do you smoke? ____ Use other tobacco products? _____Have you ever smoked or used tobacco? ____
Years? _____ Alcohol use? ___ Average drinks per week? _____Recreational Drug use current? _____ past?
EXERCISE AND ACTIVITY: How many times per week? _____Activity and duration? _____
Consistent inconsistent? _____
ARE YOU CURRENTLY OR FORMERLY INVOLVED IN:
Martial Arts ___ Kickboxing ___ Yoga ___ Gymnastics ___ Boxing ___ Cheerleading ___ Triathlons ___ Marathons ____
Professional sports ___ Olympic level amateur sports ___ Club level amateur sports ___ MMA (Mixed Martial Arts) ___
HORMONE BALANCE: Are your hormone replacement therapy? ___ How Long? _____ Which Hormones?
_____
Have your Testosterone ever been tested? _____ Low? _____ High?_____ Vit D level _____
Surgeries _____ Last menstruation _____ Hysterectomy _____
Problems with Thyroid ____ with Pituitary gland _____ with Adrenal glands ____ with Kidneys ____
Have you or a close relative had Breast Cancer? _____ Have you had Ovarian Cancer, Uterine Cancer, or Prostate Cancer? _____ If male, what is your PSA? _____ When obtained? _____
During the last year have you noticed?
___Decreased energy ___Decreased Libido ___Weight Gain ___ Lightheadedness ___ Hypoglycemia (low glucose in blood) ___ Hyperglycemia (Pre-Diabetes) ___ Diabetes ___Loss of strength ___Mood changes
___Difficulty handling stressful situations ___Loss of endurance ___Erection Problems ___Irritability
___Sleeping more ___Sleeping less ___Memory loss ___Hot flashes ___Hard to concentrate
___ Awake tired or exhausted ___ Depression ___ Auto-Immune disease _____
True or False: I was doing fine until ___ years ago. My whole body seems to be falling apart now: True ____ False ____
Have you had a Total or Partial Joint Replacement? _____ Have you had a Heart Valve Replacement? _____
Do You take Antibiotics before Dental or other Procedures?
_____

IMMUNE SYSTEM: Have you ever been told that you have: Fibromyalgia ____Chronic Fatigue Syndrome____ Lyme Disease____ Systemic Candida infection____ Hepatitis B, C or D____ Food Allergies ____ Severe seasonal allergies ____
Have you ever taken an Immuno-suppressive medication? _____ Have you ever had cancer chemotherapy? _____ Do you have frequent stomach aches, diarrhea, or bloating? ___ Do you get stomach symptoms from any food? _____ Have you been told that you have Irritable Bowel Syndrome? ____ If you have known food or any other allergies, please list_____

What is your KNOWLEDGE about PROLOTHERAPY (Regenerative injections with Platelet Rich Plasma (PRP), Dextrose and/or Prolozone):

I have read the Prolotherapy website in some detail ____
received Prolotherapy treatment by another physician ____
heard about this treatment in details from a friend ____
heard about this treatment from medical professional ____

How knowledgeable are you about this treatment?
Very ____ Fairly ____ Barely ____

PAST MEDICAL HISTORY

	YES,	**NO**	**When Diagnosed?**
Diabetes	____	____	_____
Seizure Disorder	____	____	_____
Stroke	____	____	_____
Heart Attack	____	____	_____
Angina	____	____	_____
High Blood Pressure	____	____	_____
Emphysema	____	____	_____
Asthma/Bronchitis	____	____	_____
Chronic Sinusitis	____	____	_____
Frequent colds	____	____	_____
Migraines	____	____	_____
Ringing in ears	____	____	_____
Blurred Vision	____	____	_____
Whiplash	____	____	_____
Arthritis	____	____	_____
Disc rupture	____	____	_____
Degenerative disc disease	____	____	_____
Rotator cuff injury	____	____	_____
Thyroid Disorder	____	____	_____
Adrenal Disorder	____	____	_____
Pituitary Disorder	____	____	_____
High Cholesterol	____	____	_____
Bleeding problems	____	____	_____
Hepatitis	____	____	Type_____
Chronic Fatigue	____	____	_____
Fibromyalgia	____	____	_____
Interstitial Cystitis	____	____	_____
Elevated PSA	____	____	_____
Another hormone problem	____	____	_____
Gastrointestinal problems	____	____	_____
Depression	____	____	_____
Other Psychiatric illness	____	____	_____
HIV/AIDS	____	____	_____

List any accident or injury with symptoms lasting longer than one month: _____
_____
_____

Any other conditions of any systems of the body: Cardiovascular _____, Digestive _____
Nervous _____ Genito-Urinary / Reproductive _____, Respiratory _____

Additional Notes or Medical Information: _____
_____

Patient Name (Print)	Patient signature	Date

Practitioner signature	Date