MICHIGAN REGENERATIVE SPECIALISTS STEM CELL APPLICATION

Name:

DOB: Age: Male Female

Email:

Primary Phone: Time Zone:

Address:

Ht: Wt:

Primary Care Doctor:

City, State, ZIP:

Occupation:

Hours worked/week:

What is your reason for seeking treatment?

List all areas of complaint. List how long you have had it.

1.
2.
3.
4.

List treatments tried that didn´t work.

Drug
Steroid
Surgery
Others:

On your worst day, how do you feel?

Has anything done prior made your condition better or worse?

Current medications

Are you currently on any blood thinning medications (Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Pradaxa)? Yes No

List all supplements and herbs you are currently taking

Allergies- List all known allergies to drugs/medications and reaction

List all surgeries/procedures/trauma/hospitalizations with approximate date

Social History

Yes No Do you Smoke? If Yes, How much? What age did you start?

Yes No Have you ever smoked for any period of time? If yes, when did you quit?

Yes No Do you exercise regularly?

Yes No Do you have difficulty sleeping? How many hours do you sleep at night?

Yes No Are you currently pregnant or trying to get pregnant?

Yes No Are you under a lot of stress that affects the way your function?

Please complete the following questions regarding these conditions if it is applicable to your healthcare concerns.

What is your average level of pain (0, none-10, worst)?

Condition 1

What body part is affected?	
How long have you been in pain?	
What makes it better?	
How often do you experience pain?	

Condition 2

What body part is affected?	
How long have you been in pain?	
What makes it better?	
How often do you experience pain?	

Condition 3

What body part is affected?	
How long have you been in pain?	
What makes it better?	
How often do you experience pain?	

Please list any questions or concerns

Yes	No	Health History: Current or Past
		Alcohol abuse
		Anemia
		Anxiety
		Arthritis
		Asthma
		Atherosclerosis
		Autoimmune
		Bleeding disorder
		Blood clots
		Cancer
		COPD/Emphysema
		Depression
		Diabetes
		Diverticulitis
		Heart Attack
		Herniated Disc
		High BP
		IBS
		Irregular heartbeat
		IV drug use
		Kidney stone
		Liver Disease
		Memory Loss
		Migraines
		Multiple Sclerosis
		Osteoporosis
		Reflux
		Seizures
		Stroke
		Stomack problems
		Thyroid problems
		Vision problems

Family History

Yes	No	Condition
		Heart Disease
		Autoimmune
		Cancer
		Diabetes
		Thyroid
		Other

Yes	No	Symptom
		Weight Loss
		Night sweats
		Fever
		Sleeping changes

Yes	No	Symptom
		Fatigue
		Rash, itch
		Lumps, masses
		Appetite changes

Eyes

Yes	No	Symptom
		Visual changes
		headaches
		Eye pain

Yes	No	Symptom
		Double vision
		Blind spots
		floaters

Ears, Nose, Throat, Mouth

Yes	No	Symptom
		Sinus pain
		Ear pain
		Ringing in ear

Yes	No	Symptom
		toothache
		Sore throat
		Swallowing pain

Cardiovascular

Yes	No	Symptom
		Chest pain
		Exercise intolerance
		Leg swelling

Yes	No	Symptom
		palpitations
		fainting
		Leg pain with walking

Respiratory

Yes	No	Symptom
		Cough
		Shortness of breath
		Oxygen use

Yes	No	Symptom
		wheezing
		Chronic infections
		Productive cough

Gastrointestinal

Yes	No	Symptom
		Abdominal pain
		Indegestion
		Bloating, cramping

Yes	No	Symptom
		constipation
		diarrhea
		Blood in stool

Genitourinary

Yes	No	Symptom
		Incontinence
		Blood in urine
		Irregular menses

Yes	No	Symptom
		Pain with urination
		Sexual dysfunction
		Erectile dysfunction

Skin

Yes	No	Symptom

Yes	No	Symptom

Neurological

Yes	No	Symptom

Yes	No	Symptom

Psychiatric

Yes	No	Symptom

Yes	No	Symptom

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Thank you for choosing MICHIGAN REGENERATIVE SPECIALISTS (herein referred to as “the clinic”) for your health care needs. This consent form specifies your rights in regard to your Protected Health Information (PHI) and our Treatment, Payment, and Health Care Operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent, as the Notice of Privacy Practices outlines the use and disclosure of PHI and TPO in detail. We reserve the right to revise its Notice of Privacy Practices at any time and will provide a revised copy upon request. Please carefully read the terms and conditions below:

I hereby give my consent for the clinic to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, and Health Care Operations (TPO).

With this consent, the clinic may call my home (or other alternative location) and leave a message on voicemail (or speak with me directly) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and issues pertaining to my clinical care.

With this consent, the clinic may mail to my home (or other alternative location) any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, the clinic may send me e-mails regarding any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that the clinic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that my PHI will be transmitted to a health care provider and understand that that health care provider is not able to diagnose or treat me without an exam. I understand that the health care provider will review and make recommendations, and that those recommendations should be reviewed with my personal medical team. I will not hold liable any of the recommendations and understand that no emergent condition can be treated over the telephone.

By signing this form, I am consenting to allow MICHIGAN REGENERATIVE SPECIALISTS to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent form, or later revoke it, the clinic may decline to provide treatment to me.

Acknowledgement of Privacy Practices: I acknowledge that I have been offered a copy of, and have received if requested, the Notice of Privacy Practice.

Patient Name (printed): Date:

Signature: ______________________________

Relationship to Patient: Self Parent Spouse Guardian