## CONFIDENTIAL PATIENT INFORMATION

NeuroSpinal Institute of Broward
Regenerative Medicine

Name: ______________________________________________________ DOB: ________________ S/S#__________________

Address:_____________________________________________________ City: ______________State:________Zip:________

Home:________________________ Cell: ______________________________Email:___________________________________

Male / Female (circle one) **Status:** □Minor □Married □Single □Engaged □Divorced □Widowed

Occupation: ____________________________________ Please explain your duties at work: ___________________________

Spouse/Parent's Name: _______________________________________________________________________________

Emergency contact: ________________________________________ Phone: ________________________________________

Who is your Primary Care Physician? ________________________________________Phone:__________________________

**How did you hear about us?** Facebook Website Google Friend Spouse Newspaper Article Doctor Seminar: _______

**Present Complaints –Describe main problem(s) below:**

_________________________________________________________
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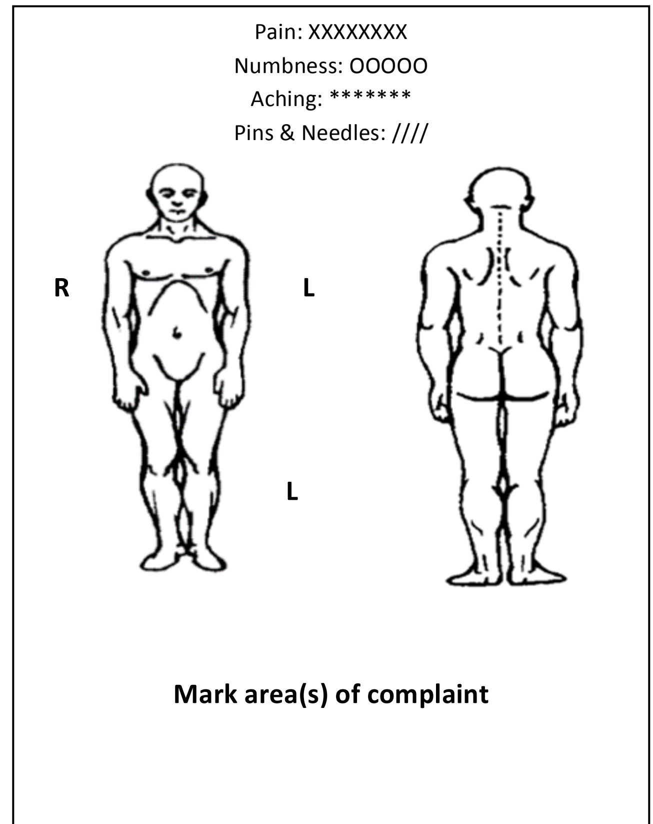


**In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own opinion what do you think the real problem is:**

______________________________________________________________________________________________
______________________________________________________________________________________________

2. **What are three things your condition has made you miss the most:**

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Patient Signature: _____________________________________________________ Date: ___________________________

**3. Severity of problem (circle)**

| Minimal | Slight | Moderate | Severe | Extreme |
|---|---|---|---|---|
| Annoying but No limitation | Tolerable but causing littler limitation | Sometimes tolerable but definitely causing limitation | Causing significant limitation | Constant limitation |

**4. How often are you aware of your main problem (circle one):**

Occasionally 25%     Intermittently 50%     Frequently 75%     Constantly 100%

5. **What relieves your symptoms or causes them to return:**

______________________________________________________________________

6. **Describe the first time you remember having symptoms:**

______________________________________________________________________

______________________________________________________________________

**7. If your symptoms include pain:**

a. What is the quality (sharp, dull, stabbing, etc.): ______________________________________?

b. Does the pain radiate? Yes or No  Location that it radiates to: ______________________

8. **Do your symptoms occur at a specific time, place or environment:** Yes or No

a. When and for how long do symptoms last for each episode?

______________________________________________________________________

______________________________________________________________________

**9. What types of treatment have you received:?**

a. Prescription / Drug therapy: ______________________________________________

b. Nutritional: ______________________________________________________

c. Alternative/Holistic: ______________________________________________

**10. List your health goals in order of importance:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Motivation to achieve these goals:** (Circle below - one being the least motivated and 10 being the most motivated)

1  2  3  4  5  6  7  8  9  10

11. **What are you hoping happens today as a result of your consultation:**

______________________________________________________________________

______________________________________________________________________

**Past/Present Medical History**: (Please check all that apply to you and write any others)

☐ Hypertension (High Blood Pressure) ☐ Hypotension (Low Blood Pressure) ☐ A-Fib/Angina Pectoris ☐ Asthma

☐ COPD ☐ Sleep Apnea ☐ HIV / AIDS ☐ Hepatitis A: ____ B:_____ C:_____

☐ Cancer What kind: __________________________ Remission Yes / No (please circle)

☐ Diabetes: Type: ____________________________ ☐ Prostate Disorder ☐ Rheumatoid Arthritis ☐ MS/ALS (please circle)

☐ Lupus ☐ Thyroid ☐ Fibromyalgia ☐ Blood Clots/ Thrombophlebitis ☐ GOUT ☐ MRSA ☐ Rosacea

☐ High Cholesterol (Hyperlipidemia) ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Epilepsy/Seizure

☐ Alzheimer's/Dementia ☐ Heart Attack ☐ Stroke Other: ______________________________________

Patients Signature:_____________________________________________ Date:_______________________

**Please list any past surgeries.**

______________________________________________________________________________

______________________________________________________________________________

**List your past history of accidents or trauma. Please indicate the year in which the accident occurred:**

______________________________________________________________________________

______________________________________________________________________________

**Please list any known allergies:** ________________________________________________________

or Circle **N/A** if you have no known allergies

**Family History** (List of your family health history. Choose all that apply to blood relatives only).

☐ No family history of diabetes, cancer hypertension and progressive neurological disorders. ☐ Not applicable, patient was adopted

☐ Alcoholism ☐ Alzheimers ☐ Arthiritis ☐ Asthma ☐ Breast lump ☐ Bronchitis ☐ Cancer ☐ Diabetes ☐ Emphysema

☐ High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Other: ________________________________________________

**Personal Habits**

Have you ever smoked? ○ Yes ○ No For how long?

Do you presently smoke? ○ Yes ○ No How much? ________________________________________________

Do you use alcoholic beverages? ○ Yes ○ No How much? ________________________________________________

Do you use recreational drugs? ○ Yes ○ No What Type? ________________________________________________

**Symptoms within past 7 days**

**Constitutional:** ▫ Recent Weight Change ▫ Fever/Chills ▫ Night sweats ▫ Feeling poorly

**Eyes/Head:** ▫ Vision problems ▫ Blurry vision ▫ Vision prescription ▫ Headache

**HENT:** ▫ Loss of hearing ▫ Ringing in the ears (tinnitus) ▫ Issues with gums/teeth ▫ Hoarseness/difficulty swallowing

**Respiratory:** ▫ Difficulty breathing ▫ Cough ▫ Shortness of breath ▫ Coughing up blood

**Digestive:** ▫ Belching/Bloating/Heartburn ▫ Nausea/Vomiting ▫ Diarrhea ▫ Constipation ▫ Abdominal Pain

**Heart:** ▫ Chest pain/discomfort ▫ Fast heart rate ▫ Palpitations

**Musculoskeletal:** ▫ Muscle weakness ▫ Neck pain ▫ Low back pain ▫ Joint swelling ▫ Joint pain

**Nervous System:** ▫ Fainting ▫ Convulsions/Seizures ▫ Tingling ▫ Numbness

**Skin:** Skin Rashes or disorder: What type: ________________________________________________

**Endocrine/Glands:** ▫ Excessive thirst/fluid intake ▫ Hot flashes ▫ Temperature intolerance (heat/cold)

**Blood/Lymph:** ▫ Easy bleeding ▫ Easy bruising ▫ Swollen glands in the neck

**Urinary System:** ▫ Blood in urine ▫ Painful urination ▫ Incontinence ▫ Penile discharge ▫ Decreased urination

**Female Reproductive:** ▫ Normal menstruation ▫ Menopausal ▫ Vaginal discharge ▫ Pelvic pain

Patients Signature:________________________________________________ Date:__________________________

**For Men Only**

Do you have pain or lump in the scrotum or testicles? ○ Yes ○ No ○ Unsure

Do you have impaired libido (sex drive)? ○ Yes ○ No ○ Unsure Do you have discharge from your penis? ○ Yes ○ No

Do you have prostate problems? ○ Yes ○ No ○Unsure When was your last prostate exam? _______ ○ Never had one

Date of last PSA (Prostate-Specific Antigen) test? _________ ○ Never had one What was your PSA level (if tested)? ________

Do you have erectile dysfunction (problem with achieving and/ or maintaining erections)? ________________________________

**For Women Only**

Are you pregnant? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Do you experience painful periods? ○ Yes ○ No

Do you have irregular cycles ○ Yes ○ No Do you perform a regular self-examination of breasts? ○ Yes ○ No

Do you have breast implants ○ Yes ○ No Do you take oral contraceptives ○ Yes ○ No

Date of last PAP/ pelvic exam? ___________ Date of last mammogram? __________ Date of last menstrual period?__________

Please list any pregnancies: ______________________________________________________________

Have you ever been a victim of abuse? ○ Yes ○ No Do you experience hot flashes ○ Yes ○ No

Are you experiencing hair loss? ○ Yes ○ No Do you have impaired libido (sex drive)? ○ Yes ○ No ○ Unsure

**Emotional Status:** □ Depression □ Sleep disturbances □ Feeling nervous

## Patient Medication List- *If you brought a list of your medications we would be more than happy to make a copy for your file. Please bring to the front desk.*

| Medication | Dose | Frequency | Date Started | Date Dc'd |
|---|---|---|---|---|
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**No treatments will be rendered until we understand completely whether your condition is a good fit for our treatments and you are comfortable with our clinical approach.**

If you are accepted as a patient, we will clearly help you understand your responsibility for services rendered. In cases where someone has insurance benefits, you are responsible for deductibles and copays that your insurance requires as well as any services not covered under your policy. For those without insurance or limited coverage, that is not a problem. We have easy and affordable payment options for you to get the care that you need. Once we have enough information to determine whether or not you can be helped in our clinic we will spend all the time necessary to help you understand your condition and what options there are to help you get better, as well as those treatments or therapies that may be available to you even outside our facility.

Patients Signature:_______________________________________________ Date:______________________

I authorize the professional staff of ______________________________ to disclose the following patients' specified information to the professional staff of **NSI Broward Regenerative Medicine.**

Patient Name: ____________________________________________________
Address: ____________________________________________________
Date of Birth: _____/______/______
Phone Number: ____________________________________________________
Social Security #: ____________________________________________________

2. Information to be released: Please FAX Please mail hardcopy

_____Complete health record
_____History and Physical Exam
_____Progress Notes
_____Radiology Reports
_____Radiology Films
_____Laboratory Reports
_____Other______________________________________________________________________________

_____Discharge Summary
_____MRI of ______________________
_____Consultation Reports
_____HIV Test Results
_____Psychiatric Records
_____Drug Screen, blood, alcohol

I understand that if complete health record is checked above all medical information will be releases including psychiatric records, alcohol or drug screening and HIV test results.

**2.** This information is to be disclosed to: **NSI Broward**
**2853 Executive Park Dr. Suite 101**
**Weston, FL 33331**
**Tel: 954-400-0479/ Fax: 954-960-6355**

**3.**

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

**4.** I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. **This authorization will expire 90 days from, the date of authorization.**

Access to medical information is the right of every patient; duplication and distribution is a service. Releases are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

X____________________________________________ **Date**______/______/______
**Signature of patient**

____________________________________________ **Please Print Name**

Signature of Legal Guardian ______________________________ Date______/______/______
Please Print Name
________________________________________________________________________________

Patients Signature:_____________________________________________ Date:______________________