REGENERATIVE
INSTITUTE OF NEWPORT BEACH

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PATIENT INFORMATION: DATE:

Name: ____________________________ Sex: ____________ Age: ____________

Date of Birth: ____________________________ Social Security: ____________________________

Cell Phone: ____________________________ Home Phone: ____________________________

Address: ____

City: ____________________________ State: ____________ Zip Code: ____________

Email Address: ____

Occupation: ____

Emergency Contact: ____________________________ Relationship: ______________________ Phone #: ______________________

Referring Physician: ____________________________ Phone #: ____________________________

Primary Care Physician: ____________________________ Phone #: ____________________________

How Did You Hear About Us: ☐ Yelp ☐ Facebook ☐ Website ☐ Family/ Friend:

CHIEF COMPLAINT:

What side is your pain in: ☐ Right ☐ Left ☐ Both

Where is your pain located?

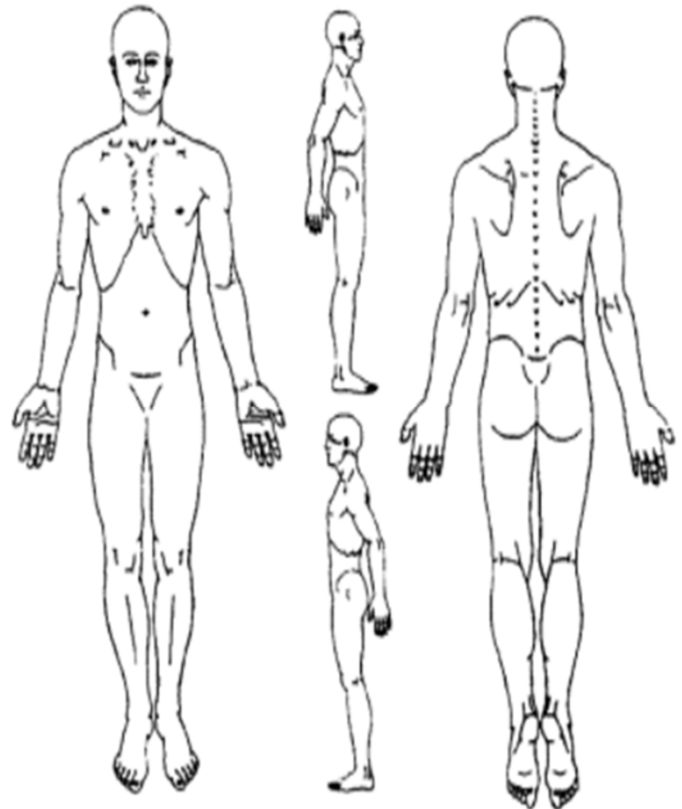
☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Neck

☐ Shoulder ☐ Arms ☐ Wrist ☐ Hands

☐ Elbow ☐ Buttocks ☐ Hip ☐ Legs

☐ Knee ☐ Ankle ☐ Foot

Draw the location of your pain by shading on the diagram to the right >>>>>>



Patient Name:____

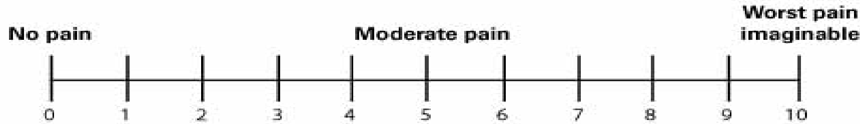
HISTORY OF PRESENT ILLNESS:

How long have you noticed the pain? _______Days _______Weeks _______Months _______Years

The pain is described as: ☐ Constant ☐ Intermittent ☐ Unchanged ☐ Worse ☐ Better

Describe your pain: ☐ Burning ☐ Sharp-Shooting ☐ Tingling ☐ Numbness ☐ Pinprick
☐ Stabbing ☐ Deep-Pressure ☐ Tightness ☐ Spasms ☐ Throbbing
☐ Tender ☐ Aching ☐ Other: _________________________

Rate your **USUAL** pain: (circle)



Was there any injury/event that caused your pain? ☐ No ☐ Yes: ____________________________________

Any prior injury or pain to the areas indicated above? ☐ No ☐ Yes: ____________________________________

Have you had surgery on any of the areas indicated above? ☐ No ☐ Yes: ____________________________________

What makes the pain **WORSE**? ____

What makes the pains **BETTER**? ____

How does the pain limit you? ____

TREATMENTS & EVALUATIONS

Check Previous Evaluations: ☐ CT ☐ MRI ☐ X-Ray ☐ EMG ☐ Bone Scan ☐ Blood/ Laboratory

Check Previous Treatment (s): ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture ☐ TENS
☐ Exercise ☐ Massage ☐ Heating Pad ☐ Ice
☐ Medications ☐ Surgery ☐ Injections ☐ Epidurals

Please List the **BEST** Treatment(s):

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

ALLERGIES: ☐ No Known Allergies

Medication / Food	Reaction

Patient Name:____

SOCIAL HISTORY:

How did/do you make a living? _________________________

Can you dress yourself? ☐ Yes ☐ No

Alcohol Use: ☐ None ☐ Occasional ☐ Daily

Smoking: ☐ No ☐ Quit ☐ Yes: Packs per day: _______ Number of years: _______

Recreational Substances: ☐ No ☐ Yes: _________________________

MEDICAL HISTORY: ☐ No Known Medical History

Please check medical conditions:

☐ Arthritis ☐ Bleeding Disorder ☐ Diabetes ☐ Depression ☐ Cancer: _________________

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Osteoporosis ☐ Other: _________________________

SURGICAL HISTORY: ☐ No Past Surgical History

Please list any surgical procedures:

Year	Surgery	Hospital	Doctor

FAMILY HISTORY:

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer: _________________________

Mother: _______ years old Healthy Deceased due to: _________________________

Father: _______ years old Healthy Deceased due to: _________________________

CURRENT MEDICATIONS & DOSAGES: ☐ No Current Medication

List all medications you are currently taking including over-the-counter, herbs, vitamins, and dietary supplements:

Medication Name	Dose	Frequency	Prescribing Doctor

Patient Name:____

REVIEW OF SYSTEMS:

Please fill out **CURRENT** symptoms only.

SKIN
- [ ] Normal
- [ ] Skin Rash
- [ ] Easy Bruising/bleeding
- [ ] Abnormal Hair Loss
- [ ] Nail Ridging, pitting

NEUROLOGICAL
- [ ] Normal
- [ ] **Headaches**
- [ ] **Incontinence**
- [ ] Seizures
- [ ] Paralysis

EYES
- [ ] Normal
- [ ] Visual Loss
- [ ] Color Blindness
- [ ] Glaucoma
- [ ] Glasses/ Contacts

LYMPH NODES
- [ ] Normal
- [ ] Enlargement
- [ ] Pain

EARS/NOSE
- [ ] Normal
- [ ] Deafness
- [ ] Vertigo/Dizziness
- [ ] Hoarseness
- [ ] Sinusitis
- [ ] Post Nasal Drip

GENITOURINARY
- [ ] Normal
- [ ] Blood in Urine
- [ ] Impotence
- [ ] Painful Urination
- [ ] Kidney Stones
- [ ] Venereal Disease
- [ ] Urinary Incontinence
- [ ] Saddle Anesthesia

BONE/JOINT MUSCLES
- [ ] Normal
- [ ] Dislocation
- [ ] Fracture
- [ ] Muscle Wasting
- [ ] Muscle Pain
- [ ] Muscle Weakness
- [ ] Lower Extremity Weakness

RESPIRATORY SYSTEM
- [ ] Normal
- [ ] Shortness of Breath
- [ ] Cough
- [ ] Asthma/Bronchitis
- [ ] Tuberculosis
- [ ] Pneumonia

MENTAL STATUS
- [ ] Normal
- [ ] Hallucinations
- [ ] Nervous Breakdown
- [ ] **Depression**
- [ ] **Sleep Disturbances**

BLOOD SYSTEM
- [ ] Normal
- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] Blood Thinners

ENDOCRINE
- [ ] Normal
- [ ] Abnormal Growth
- [ ] Goiter
- [ ] Heat/Cold Intolerance
- [ ] Increase Thirst

CARDIOVASCULAR
- [ ] Normal
- [ ] Palpitations
- [ ] Chest Pains
- [ ] Leg Swelling
- [ ] Arrhythmia

CONSTITUTIONAL
- [ ] Normal
- [ ] Fever/Chills
- [ ] Weight Loss
- [ ] Nausea
- [ ] Vomiting

ALLERGIES
- [ ] Normal
- [ ] Dermatitis
- [ ] Hay Fever
- [ ] Migraine
- [ ] Sensitivity to Pollen

GASTROINTESTINAL
- [ ] Normal
- [ ] Appetite Changes
- [ ] Jaundice
- [ ] Hemorrhoids
- [ ] Irritable Bowels
- [ ] Bowel Incontinence

GENERAL
- [ ] Normal
- [ ] Poor Sleep
- [ ] Poor Energy
- [ ] Eat Too Much/ Little
- [ ] Unhappy

____

Reviewing Physician Signature