

Regenerative Medicine Patient Intake Form

1. Patient Demographics

Full Legal Name: _____

Date of Birth: _____ Age: _____

Sex Assigned at Birth: Male Female Other

Address: _____

City: _____ State: _____ Zip: _____

Phone (Cell): _____

Phone (Home): _____

Email: _____

Occupation: _____

Employer: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Primary Care Provider: _____

Referring Provider (if applicable): _____

2. Chief Complaint

What joint or body part is bothering you?

Side: Right Left Both

How long have you had this problem?

< 6 weeks 6 weeks – 6 months 6 months – 1 year > 1 year

How did this start?

Gradual onset Specific injury Sports-related Work-related Unknown

Describe your symptoms in your own words:

3. Pain & Functional Assessment

Pain level (0-10): _____

Pain is: Sharp Dull Aching Burning Stiffness Instability

What makes it worse? _____

What makes it better? _____

How does this limit your activities?

4. Imaging History (Important)

Have you had imaging of this joint/body part within the last 6 months?

Yes No

If yes, please indicate type and date:

X-ray – Date: _____ Facility: _____

MRI – Date: _____ Facility: _____

CT scan – Date: _____ Facility: _____

Ultrasound – Date: _____

Do you have copies of the report and/or images? Yes No

5. Surgical & Injury History

Have you ever had surgery on this joint/body part? Yes No

If yes, type of surgery and date:

Have you had a recent injury (within last 3 months)? Yes No

If yes, describe:

6. Prior Treatments

- Physical therapy Chiropractic care Anti-inflammatory medications (NSAIDs)
 Oral steroids Cortisone injection Hyaluronic acid injection
 PRP Stem cell treatment Surgery Bracing
 Other: _____

Did these treatments help?

7. Medical History

- Diabetes Autoimmune disease Rheumatoid arthritis Cancer (current or past)
 Blood clotting disorder Bleeding disorder Chronic infection Hepatitis
 HIV Heart disease Kidney disease Liver disease
 Neurologic disorder Immunosuppression
 Other: _____

8. Medications

List all current medications (including blood thinners):

Are you taking any of the following?

- Aspirin Plavix Warfarin Eliquis Xarelto
 Steroids Biologic medications Chemotherapy None

9. Allergies

Do you have any medication allergies? Yes No

If yes, list reaction:

Latex allergy? Yes No

10. Regenerative Medicine Screening

Have you had regenerative injections before?

PRP Bone marrow aspirate Adipose-derived cells Other: _____ No

Did you have any complications?

Are you currently pregnant or breastfeeding? Yes No

Do you have any active infection anywhere in your body? Yes No

Have you had a fever in the last 2 weeks? Yes No

11. Lifestyle Factors

Do you smoke? Yes No

Alcohol use: None Occasional Moderate Heavy

Activity level: Sedentary Recreationally active Competitive athlete

12. Patient Understanding & Expectations

May not be covered by insurance

Are not guaranteed to cure my condition

Are intended to support healing and symptom improvement

May require imaging and/or diagnostic evaluation prior to treatment

I understand that additional imaging may be recommended before proceeding.

13. Consent to Evaluate

I certify that the information provided is accurate and complete to the best of my knowledge.

I understand that withholding medical information may increase risk of complications.

Patient Signature: _____

Date: _____