Stem Cell Patient Intake

Patient Name: ________________________________ DOB: ____/____/______

Address: ____

____

City State Zip

Tel. ( ) ______-__________ Alt. ( ) ______-__________

Email:__________________________Employer/Occupation________________

Emergency Contact: ______________________________Relation:__________

Tel. ( ) ______-__________

ALLERGIES:

____

HISTORY: Please indicate if you have been diagnosed or have history of the following:

YES NO
- **Cancer or Metastatic disease**

YES NO
- **An active local infection**

YES NO
- **Pregnant or are breastfeeding**

YES NO
- **A low platelet count (thrombocytopenia)**

YES NO
- **Anemia or low HGB count**

YES NO
- **Platelet dysfunction syndrome**

YES NO
- **Antiplatelet therapy**

YES NO
- **Active Smoking Habit**

YES NO
- **Alcohol Overuse**

YES NO
- **Allergic to cows**

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YES NO • **Septicemia or blood infection**

YES NO • **Local toxicity to Bupivacaine HCL or Lidocaine**

YES NO • **Corticosteroid injection and NSAIDS**

YES NO • **Recent fever or illness**

Please explain any “yes” answers:
____
____
____

Past Surgeries:
Procedure:______________________________Date:_____________________
Procedure:______________________________Date:_____________________
Procedure:______________________________Date:_____________________

Medications:
Type:____________________________Freq/Dosage:_____________________
Type:____________________________Freq/Dosage:_____________________
Type:____________________________Freq/Dosage:_____________________

Social: Tobacco use _______ Alcohol use ________

Other Medical History (Hyperthyroid, Hypertension):
____
____
____
____

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Pain Questionnaire (Check all that apply)

Severity: Mild ___ Moderate ___ Severe _____ Pain Level: _________

Duration: <3 months _____ > 3 months _____ mos/ yrs ________

Timing: Morning ______ Evening _____ Continuous ____ Other __________

Associated Symptoms: Popping ________ Clicking _______

Instability _______ Swelling _______

Limitations:

Interrupts sleep >3 hours night _______ Difficulty getting out of bed _______

Difficulty carrying groceries ______

Unable to manage 10 stairs consecutively ________

Unable to stand for 60 minutes without pain _______

Unable to walk 2 blocks uninterrupted _______

Previously tried the following intervention for pain relief for a period of ________ months without full relief:

Tylenol _____ NSAIDs________ Steroids ______ HLA ____

Prescription pain reliever ____________________________

Physical therapy _________

Other _________________________

Patient Name (print): _______________________ Date:____________

Patient Signature: _______________________________________

Physician Name (print:______________________Date:____________

Physician Signature:____