Demographic Information

First Name MI Last Name: _____ DOB _____

Address: _____ State: _____ ZIP Code: _____

Phone: _____Email: _____

Emergency Contact:_____Phone: _____Relation: _____

Primary Care Physician: _____Office Phone: _____

Employer: _____Occupation: _____

Primary Insurance Provider: _____ Supplemental Insurance Provider: _____

SSN# _____

Please provide ID and insurance cards

Payment for Services Rendered: We here at Regen Osteo will do our utmost to obtain payment from your insurance company. We will submit claims on your behalf, keep you informed of issues, and may ask you to call your insurance if we are unable to proceed on your behalf. If you have copay and/or coinsurance or do not have insurance, we still expect payment at time of service when due. By signing, you understand that benefits quoted may or may not be paid by your insurance and you are responsible for payment should insurance not cover rendered services.

X _____

Authorization of Benefits: I give Regen Osteo full authorization to attempt to bill and collect said payments on my behalf from insurance companies which may entail submission of any relevant medical records to prove medical necessity. If my carrier denies my claims because the benefits were quoted in error, or because they deem the services NOT to be medically necessary, and my provider could not have reasonably known that the services would be denied, I understand that I will be financially responsible for the services in question.

X _____

Consent for Treatment: I authorize Regen Osteo to perform necessary diagnostic testing including, but not limited to, x-rays with contrast and administer treatment as indicated. I agree that all treatment decisions are reached via shared decision making between myself and the provider

X _____

Consent for Records/Protected Health Information: I understand Regen Osteo will keep my records for up to 10 years as required by law, and that I may request these records as needed. I may revoke consent at any point in writing, should I do so the practice has the right to revoke treatment.

X _____

Review of Systems **Patient Name:** _____ **Date:** _____

Constitutional

- [ ] Deny All
- [ ] Chills
- [ ] Drowsiness
- [ ] Fainting
- [ ] Fatigue
- [ ] Fever
- [ ] Night Sweats
- [ ] Weakness
- [ ] Weight Gain
- [ ] Weight Loss

Eyes

- [ ] Deny All
- [ ] Blindness
- [ ] Blurred Vision
- [ ] Cataracts
- [ ] Change in Vision
- [ ] Double Vision
- [ ] Dry Eyes
- [ ] Eye Pain
- [ ] Field Cuts
- [ ] Glaucoma
- [ ] Light Sensitivity
- [ ] Tearing
- [ ] Glasses/Contacts

Cardiovascular

- [ ] Deny All
- [ ] Angina
- [ ] Chest Pain
- [ ] Claudication
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Orthopnea
- [ ] Palpitations
- [ ] Shortness of Breath
- [ ] Leg Swelling
- [ ] Varicose Veins

Respiratory

- [ ] Deny All
- [ ] Asthma
- [ ] Bronchitis
- [ ] Dry Cough
- [ ] Productive Cough
- [ ] Coughing Up Blood
- [ ] Difficulty Breathing
- [ ] Difficulty Sleeping
- [ ] Hemoptysis
- [ ] Pneumonia
- [ ] Sputum Production
- [ ] Wheezing

Musculoskeletal

- [ ] Deny All
- [ ] Arthritis
- [ ] Neck Pain
- [ ] Decreased Motion
- [ ] Gout
- [ ] Injuries
- [ ] Joint Pain
- [ ] Joint Stiffness
- [ ] Locking Joints
- [ ] Back Pain
- [ ] Muscle Cramps
- [ ] Muscle Pain
- [ ] Muscle Twitching
- [ ] Muscle Weakness
- [ ] Swelling

Integumentary

- [ ] Deny All
- [ ] Breast Lumps/Pain
- [ ] Change in Nail Texture
- [ ] Change in Skin Color
- [ ] Eczema
- [ ] Hair Growth
- [ ] Hair Loss
- [ ] History of Skin Disorders
- [ ] Hives
- [ ] Itching
- [ ] Paresthesia
- [ ] Rash
- [ ] Skin Lesions
- [ ] Chronic Wounds
- [ ] Open Wounds

Gastrointestinal

- [ ] Deny All
- [ ] Abdominal Pain
- [ ] Belching
- [ ] Black Tarry Stool
- [ ] Constipation
- [ ] Diarrhea
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Jaundice
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Abnormal Stool Caliber
- [ ] Abnormal Stool Color
- [ ] Abnormal Stool Consistency
- [ ] Vomiting
- [ ] Vomiting Blood

Genitourinary

- [ ] Deny All
- [ ] Birth Control Therapy
- [ ] Burning Urination
- [ ] Cramps
- [ ] Erectile Dysfunction
- [ ] Frequent Urination
- [ ] Hesitance / Dribbling
- [ ] Hormone Therapy
- [ ] Irregular Menstruation
- [ ] Lack of Bladder Control
- [ ] Prostate Problems
- [ ] Urine Retention
- [ ] Vaginal Bleeding
- [ ] Vaginal Discharge

ENMT

- [ ] Deny All
- [ ] Bad Breath
- [ ] Dentures
- [ ] Deviated Septum
- [ ] Difficulty Swallowing
- [ ] Discharge
- [ ] Dry Mouth
- [ ] Ear Drainage
- [ ] Ear Pain
- [ ] Frequent Sore Throats
- [ ] Head Injury
- [ ] Hearing Loss
- [ ] Hoarseness
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Nasal Congestion
- [ ] Nose Bleeds
- [ ] Post Nasal Drip
- [ ] Sinus Infections
- [ ] Runny Nose
- [ ] Snoring
- [ ] Sore Throat
- [ ] Ringing in Ears
- [ ] TMJ Problems
- [ ] Ulcers

Neurological

- [ ] Deny All
- [ ] Change in Concentration
- [ ] Change in Memory
- [ ] Dizziness
- [ ] Headache
- [ ] Imbalance
- [ ] Loss of Consciousness
- [ ] Loss of Memory
- [ ] Numbness
- [ ] Seizures
- [ ] Sleep Disturbances
- [ ] Slurred Speech
- [ ] Stress
- [ ] Strokes
- [ ] Tremors

Psychiatric

- [ ] Deny All
- [ ] Agitation
- [ ] Anxiety
- [ ] Appetite Changes
- [ ] Behavioral Changes
- [ ] Bipolar Disorder
- [ ] Confusion
- [ ] Convulsions
- [ ] Depression
- [ ] Homicidal Ideations
- [ ] Insomnia
- [ ] Location Disorientation
- [ ] Time Disorientation
- [ ] Memory Loss
- [ ] Substance Abuse
- [ ] Suicidal Ideation

Endocrine

- [ ] Deny All
- [ ] Cold Intolerance
- [ ] Diabetes
- [ ] Excessive Appetite
- [ ] Excessive Thirst
- [ ] Goiter
- [ ] Hair Loss
- [ ] Heat Intolerance
- [ ] Unusual Hair Growth
- [ ] Voice Changes

Hematologic/Lymphatic

- [ ] Deny All
- [ ] Anemia
- [ ] Bleeding
- [ ] Blood Clots
- [ ] Blood Transfusions
- [ ] Bruise Easily
- [ ] Lymph Node Swelling

Allergic/Immunology

- [ ] Deny All
- [ ] History of Anaphylaxis
- [ ] Itchy Eyes
- [ ] Sneezing
- [ ] Specified Food Intolerance

Osteoarthritis Subjective/HPI

Print Name: _____ Date of Birth: _____

Allergies to Medications/Dyes: _____

Chief Complaint: (check all that apply) ☐ Right knee ☐ Left knee
☐ Pain ☐ Stiffness ☐ Mobility ☐ Instability

When did probem/pain begin? _____

Precipitating event/injury? ☐ None ☐ Running ☐ Climbing ☐ A fall ☐ Squatting
☐ Lifting ☐ Motor vehicle accident ☐ Lifting ☐ Other_____

Pain level: (0 = no pain, 10 = worst pain) **Average:** _____ **Worst:** _____

What makes pain worse? (check all that apply) ☐ Sitting ☐ Standing ☐ Walking ☐ Getting dressed
☐ Going up stairs ☐ Going down stairs or incline ☐ Carrying +10 pounds ☐ Driving ☐ Dancing
☐ Working ☐ Laying down ☐ Jumping ☐ Knelling ☐ Squatting ☐ Extending knee straight ☐ Bending

What makes pain better? (check all that apply) ☐ Aspirin ☐ NSAID's (e.g. Advill,/Motrin,/Aleve
☐ Heat ☐ Ice ☐ Rest ☐ Knee elevation ☐ Extending the knee ☐ Bending the knee ☐ Nothing

Frequency of symptoms:
☐ Constant (76-100% of the day) ☐ Frequent (51-75% of the day)
☐ Occasional (26-50% of the day) ☐ Infrequent (1-25% of the day)

Nature of symptoms: (check all that apply)
☐ Sharp ☐ Shooting ☐ Dull ☐ Numbness ☐ Tingling ☐ Burning ☐ Radiating ☐ Throbbing
☐ Aching ☐ Stabbing ☐ Clicking ☐ Knee gives out ☐ Locking ☐ Swelling ☐ Stiffness

Mechanism of injury or pain:
☐ Gradual onset ☐ Sudden onset ☐ Traumatic

I am able to walk:
☐ < 5 minutes ☐ < 10 minutes ☐ < 15 minutes ☐ < 30 minutes ☐ 30 minutes
☐ 45 minutes ☐ One hour ☐ Only a few steps ☐ Around the house only

Medical History: Please check if you have ever had any of the following:

- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood clotting disorder
- ☐ Cancer (type: _____)
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heartburn
- ☐ Heart disease/failure
- ☐ Hernia (type: _____)
- ☐ Hepatitis (type: _____)
- ☐ Herniated disk
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hormone deficiency (E/T)
- ☐ Kidney disease/failure
- ☐ Liver disease
- ☐ Memory disorder
- ☐ Osteoporosis
- ☐ Prostatic enlargement/BPH
- ☐ Sleep apnea
- ☐ Stroke/TBI
- ☐ Sexual difficulty
- ☐ Thyroid disease
- ☐ Urinary difficulty (over/underactive)
- ☐ Ulcer (type: _____)

If not mentioned above, please list here:

_____

Please list any allergies:

_____

Social History (circle): Smoker? Never Alcohol? Never *Monthly/Social/Never*

Family History: P-parent S-sibling O-offspring GP-grandparent X-other

Anemia _____
Bleeding disorder _____
Hypertension _____
Cancer: type? _____
Osteoporosis _____
Kidney disease _____
Thyroid disease _____
Memory disorder (Alzheimer's) _____
Movement disorder (Parkinson's) _____
Other _____

Fall Risk Assessment

Have you fallen in the last year? No
Do you lose your balance when standing? No
Do you lose balance when getting up from sitting? No
Do you get dizzy, faint, or have seizures? No
Does it take more than one try to get out of a chair/bed? No
Do you trip over your own feet? No
Do you sometimes bump into corners or door frames? No
Do you use a walker, cane, or other assistive device to get around? No

Please list medications on back of this page, if you have a list we can make a copy :)

I have tried and failed with conservative therapy of at least 90 days e.g. (including dates)

- ☐ NSAID (anti-inflamatories, i.e aspirin, Advil, Motrin, Celebrex) Dates: _____
- ☐ Acetaminophen (i.e. Tylenol) Dates: _____
- ☐ Topical creams (i.e. Diclofenac, Voltaren) Dates: _____
- ☐ Weight reduction (if overweight) Dates: _____
- ☐ Cardiovascular (aerobic) activity such as: walking, biking, stationary bike, aquatic exercise Dates: _____
- ☐ Physical therapy Dates: _____
- ☐ Occupational therapy Dates: _____
- ☐ Participation in self-management programs Dates: _____
- ☐ Wear of medically directed patella taping Dates: _____
- ☐ Thermal agents Dates: _____
- ☐ Walking aids Dates: _____
- ☐ Resistance exercise Dates: _____

Patient Name: _____ **DOB:** _____

RIGHT KNEE

Surgical History:

☐ Arthroscopic surgery ☐ Total knee replacement

History of previous injections

☐ Steroid injections Date: _____

☐ Hyaluronic acid injections Date: _____

If prior injections, did you get pain relief? ☐ Yes ☐ No ☐ Partial

Additional notes:

_____

_____

_____

Last imaging (x-ray/MRI): _____

LEFT KNEE

Surgical History:

☐ Arthroscopic surgery ☐ Total knee replacement

History of previous injections

☐ Steroid injections Date: _____

☐ Hyaluronic acid injections Date: _____

If prior injections, did you get pain relief? ☐ Yes ☐ No ☐ Partial

Additional notes:

_____

_____

_____

Last imaging (x-ray/MRI): _____

Patient Signature: _____ Date: _____

Discussed/Reviewed by Provider: _____ Date: _____