LIFE ALIGNED
WELLNESS CENTER

Stem Cell Consultation

Please fill out the application entirely and legibly.
We need all information for Insurance purposes.

PERSONAL INFORMATION

Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ Age _____ Social Security (optional)_____

Driver's License Number _____ State issued _____

Insurance Company _____ Group # _____

Emergency Contact _____ Ph.# _____ Relationship: _____

Spouse's Name _____ Phone Number _____

Your Occupation _____ Retired? Yes No

REVIEW OF SYMPTOMS

(Please check **ALL** that apply)

___ Foot Pain
___ Hand Pain
___ Low Back Pain
___ Neck Pain
___ Foot Numbness
___ Hand Numbness
___ Leg Pain

___ Plantar Fasciitis
___ Morton's Neuroma
___ Foot Surgery

___ Diabetes
___ High Cholesterol
___ High Blood Pressure
___ Vascular Problems
___ Pacemaker/Defibrillator
___ Cancer
___ Chemotherapy
___ Implanted Cord/ Bladder Stimulator
___ Poor Circulation
___ Poor wound healing

___ Herniated Disc
___ Bulging Disc
___ Spinal Stenosis
___ Degenerative Disc
___ Arthritis in Hands
___ Arthritis in Feet
___ Sciatica

___ Pinched Nerve
___ Joint Replacement
___ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected.

1. _____
2. _____

List approximately how long you have noticed these problems:

1. _____
2. _____

Is there a certain time of day any of these problems are better or worse?

_____

_____

Circle the things you have used for these problems:

Gabapentin *Neurontin* *Lyrica* *Cymbalta*
Physical Therapy *Pain Medications* *Aleve*
Tylenol *Ibuprofen* *Motrin* *Chiropractic*
Massage Therapy *Injections* *Creams*

Is your balance/walking ability affected? If yes, please describe:

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Have your symptoms: Improved Worsened Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please circle **ALL** that apply.

Aching Pain	Numbness	Hot Sensation	Cramping	Stabbing Pain	Throbbing Pain
Tingling	Tingling	Swelling	Sharp Pain	Pins & Needles	Pain
Dead Feeling	Burning	Tiredness	Heavy Feeling	Cold Hands/ Feet	Electric Shocks

Is this condition interfering with any of the following? Please circle **ALL** that apply.

Sleep	Work	Daily Activities
Recreational Activities	Walking	Standing

Name of all the doctors you have seen for these problems and treatment you received:

_____

_____

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many cigarettes daily? _____

Do you drink? Yes No If yes, how many drinks daily? _____

Do you exercise regularly? Yes No If yes, how much exercise daily? _____

PREVIOUS HEALTH CONDITION

Please give the name, address, and office phone number of your primary care physician.

Name _____ Phone _____

Address _____

When were you last seen there? _____

May we send them updates on your treatment/condition? Yes No

List ALL allergies/sensitivities to medication, food, and other items here:

Item that you reacted to:	Reaction:
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

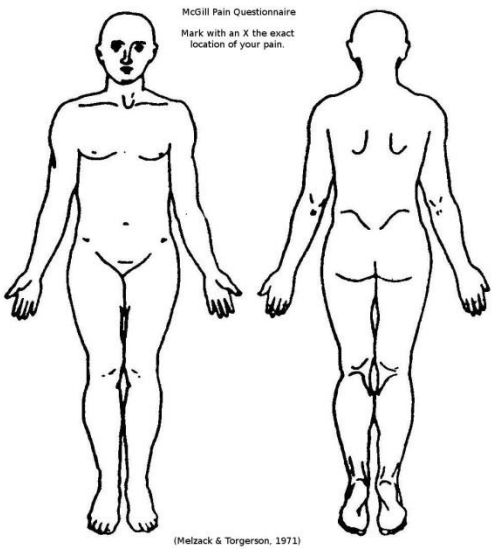
Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the nutritional supplements you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please mark the area & type of pain on the drawings using the codes listed below.

N – Numbness	P – Pain
T – Tingling	A – Ache
S – Soreness	ST – Stiffness



Financial Release and Assignment:

Payment is expected on the date that services are rendered. Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility. I understand any outstanding accounts beyond 60 days may result in a 2% finance charge per month. If the account is sent to collections, any fees associated with the collection of charges will also be billed to the patient (according to Collection Agency fee amounts). I authorize the release of any information necessary to process my insurance claims and request payment be sent directly to my physicians.

****WOMEN ONLY - Pregnancy Release**

This is to certify that, to the best of my ability, I am not pregnant.

_____I am or may be pregnant

_____I am NOT pregnant

Consent to Receive Medical Care

I, the undersigned, give this office and its doctor(s) permission and authority to provide care in accordance with standard medical tests, analysis, diagnosis, and treatment. Medical care seldom causes complications, but in rare cases, due to underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. The doctor(s) will not provide care, without consent of the patient, if they are aware of any contraindication that may be present. It is the responsibility of the patient to discuss with the doctor(s) any known underlying deformities or defects that may not otherwise come to the attention of the doctor. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known, is in my best interests.

HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office from all liability and give permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

Disclosure of Chiropractic Physician Ownership

NOTICE TO PATIENTS:

Your physician, Dr. Cox is owner of and/or has interests in Life Aligned Regenerative Medical Center, PLLC, whose services to the community include the Medical Office Building and Life Aligned Regenerative Medical Center.

You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Life Aligned Regenerative Medical Center.

You will not be treated differently by your Chiropractic Physician or NP if you choose to obtain healthcare services at a facility other than Life Aligned Regenerative Medical Center.

If you have questions concerning this disclosure please feel free to ask your Physician. We welcome you as a patient and value our relationship with you.

Patient Signature _____ Date _____