COMPREHENSIVE HEALTHCARE
CHC REGENERATIVE MEDICINE

Patient Information

Date:

Name

(Last) (First) (MI)

Email Address:

Mailing Address:

City: State: Zip:

Home Phone: Work Phone: Mobile:

Date of Birth: Sex: ☐ Male ☐ Female SS#:

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other:

Race: ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino

Emergency Contact Information:

In the event of an emergency, who would you like us to contact?

Name: Relationship:

Mobile: Home Phone: Work Phone:

How did you hear about our practice?

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Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude concerns, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign Here: _____ I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Comprehensive Health Care INC.
(Please initial one of the following options and sign below.)

- ☐ I wish to receive a paper copy of Privacy Notice.
- ☐ I do not request of copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the privacy Notice is posted in the office. If I should have a problem or question in regards to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months or prescriptions history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date

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Patient Questionnaire

Name: _____ Age: _____ Date: _____

Select below all joints and areas you would like to have evaluated.

☐ R Knee ☐ L Knee ☐ R Shoulder ☐ L Shoulder ☐ R Hip ☐ L Hip ☐ R Ankle ☐ L Ankle ☐ Low Back ☐ Neck

☐ R Elbow ☐ L Elbow ☐ R Hand/Wrist ☐ L Hand/Wrist ☐ R Foot ☐ L Foot ☐ Wellness Infusion

Other: _____

Do you Smoke? How Much? How long? _____

What caused your pain? (e.g. work related, fall, car accident, spontaneous, etc. _____

Select your pain score **TODAY**! →

No Pain			Moderate Pain						Worst Pain
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

What is the pain score on your **BEST** day? _____ / 10 What is the pain score on your **WORST** day? _____ / 10

Previous Tests: (Select ALL that apply)

☐ Bone Scan ☐ CT Scan ☐ Discogram ☐ EMG (nerve conduction)
☐ MRI ☐ Myelogram ☐ Thermography ☐ X-Ray

Past Medical History: (Select ALL that apply)

☐ Asthma
☐ Bleeding problems
☐ Bleeding ulcers
☐ Blindness
☐ Bowel problems
☐ Cancer
☐ Chronic Fatigue Syndrome
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy / seizures
☐ Fibromyalgia
☐ Headaches
☐ Heart attack / MI
☐ Heartburn
☐ Heart failure
☐ Hepatitis ☐A ☐B ☐C
☐ Hiatal hernia
☐ High blood pressure
☐ High cholesterol / lipids
☐ HIV / AIDS
☐ Kidney disorder
☐ Liver disorder
☐ Lung disorder
☐ Paralysis
☐ Psychiatric disorder
☐ Stoke / CVA
☐ Substance abuse ☐alcohol ☐drug ☐other
☐ Thyroid disorder
☐ Ulcers (GI tract)
☐ Valve problems

Past Surgical History: (Select ALL that apply and include date)

☐ Appendectomy _____ ☐ Gallbladder _____ ☐ Hip _____ ☐ Low back _____
☐ Carotid _____ ☐ Heart _____ ☐ Hysterectomy _____ ☐ Neck _____
☐ Cataract _____ ☐ Hernia _____ ☐ Knee _____ ☐ Tonsils _____

Other _____

Current Medications/Medical Care: _____

Surgical History/Allergies: _____

Women Only: Date of LMP: _____ Any Possibility of pregnancy: ☐ Yes ☐ No

This form has been filled out to the best of my knowledge _____

Family/Social History: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Cigarettes ___ packs per/day
☐ Alcohol ___ drinks/week ☐ Caffeine ___ cups/day