Regenerative Medicine of Southern Indiana Patient Information

Date_____

Name_____
(Last) (First) (M.I.)

Email Address_____

Address_____City_____State/Zip_____

Phone (Home)_____Phone (Cell)_____

Date of Birth_____ Age____ Sex: _____M _____F SSN_____

Marital Status: _____Single _____Married _____ Divorced _____ Widowed _____ Minor

Race: _____Caucasian _____African American _____ Asian _____ Native American
_____ Latin American _____ Other

Ethnicity: _____ Hispanic _____ Latino _____ Non-Hispanic

Emergency Contact
Name_____ Relation_____ Phone #_____

How did you hear about our practice? _____

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Regenerative Medicine of Southern Indiana. (Please initial one of the following options and sign below)

_____ I wish to receive a copy of the Privacy Notice

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time.

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. I also agree to receive communication regarding promotions, special offers, and updates on policies and procedures.

_____ _____
Signature of patient/guardian Date

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Name: _____ DOB:_____ Age:_____ Date:_____

Please tell us what brings you in today? _____

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Loss of Memory
- ☐ Measles
- ☐ Mononucleosis
- ☐ Nausea
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Sinus
- ☐ Skin Rashes
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Other

Please explain:

_____

_____

_____

_____

Metabolic/Nutritional

- ☐ Anorexia
- ☐ Appendicitis
- ☐ Cold Sores
- ☐ Bleeding Disorders
- ☐ Constipation
- ☐ Blurred Vision
- ☐ Bowel/Bladder Change
- ☐ Bulimia
- ☐ Cold Feet/Hands
- ☐ Dizziness
- ☐ Fatigue
- ☐ Goiter
- ☐ Weight Gain
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches
- ☐ Insomnia
- ☐ Liver Disease
- ☐ Light Bothers Eyes
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Sleeping Difficulties
- ☐ Stomach Problems
- ☐ Sudden Weight Loss
- ☐ Ulcers
- ☐ Food Cravings
- ☐ Vitamin D Deficiency
- ☐ Abdominal Pain

Physical

- ☐ Arthritis
- ☐ Neck Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Sciatica
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Numbness/Tingling
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Osteoporosis

Hormonal

- ☐ Depression
- ☐ Low Body Temp
- ☐ Migraines
- ☐ Miscarriage
- ☐ Nervousness
- ☐ Prostate Problems
- ☐ Breast Lump
- ☐ Suicide Attempt
- ☐ Vaginal Infections
- ☐ Low Libido
- ☐ Oral Contraceptive Use
- ☐ Thyroid Problems

Cardiology

- ☐ Ankle Swelling
- ☐ Arm/Hand Pain
- ☐ Cold Sweats
- ☐ Chest Pain
- ☐ Fainting
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Carotid Artery Blockage
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Low Magnesium
- ☐ Low Potassium
- ☐ Stroke

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Name: _____ DOB: _____ Age: _____ Date:_____

Are you currently under drug and/or medical care? ___Yes ___No Primary Dr_____
* Please list all medications and/or supplements on the next sheet

Allergies: _____
WOMEN ONLY: Date of last menstrual period: _____ Possibility of pregnancy:_____
Surgical History (Type and Date): _____
_____
Family History: (Indicate parents, grandparents, children and siblings)

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Arthritis _____
- ☐ Other _____

Social History:
Cigarettes _____ Pack/Day Alcohol _____ Drinks/Week Caffeine _____ Cups/Day
Exercise Frequency: ___ Never ___Daily ___ Weekly ___Walks ____Runs ___Swims

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 foes not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any conditions 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 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 person 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.

I have read and understand the above consent form

_____ _____
Signature of patient/guardian Date

Please list any/all prescription medications and/or supplements below:

Medication Name and Current Dose	How long have you been taking this?	What is it for?	Side Effects (For Doctor Use Only)

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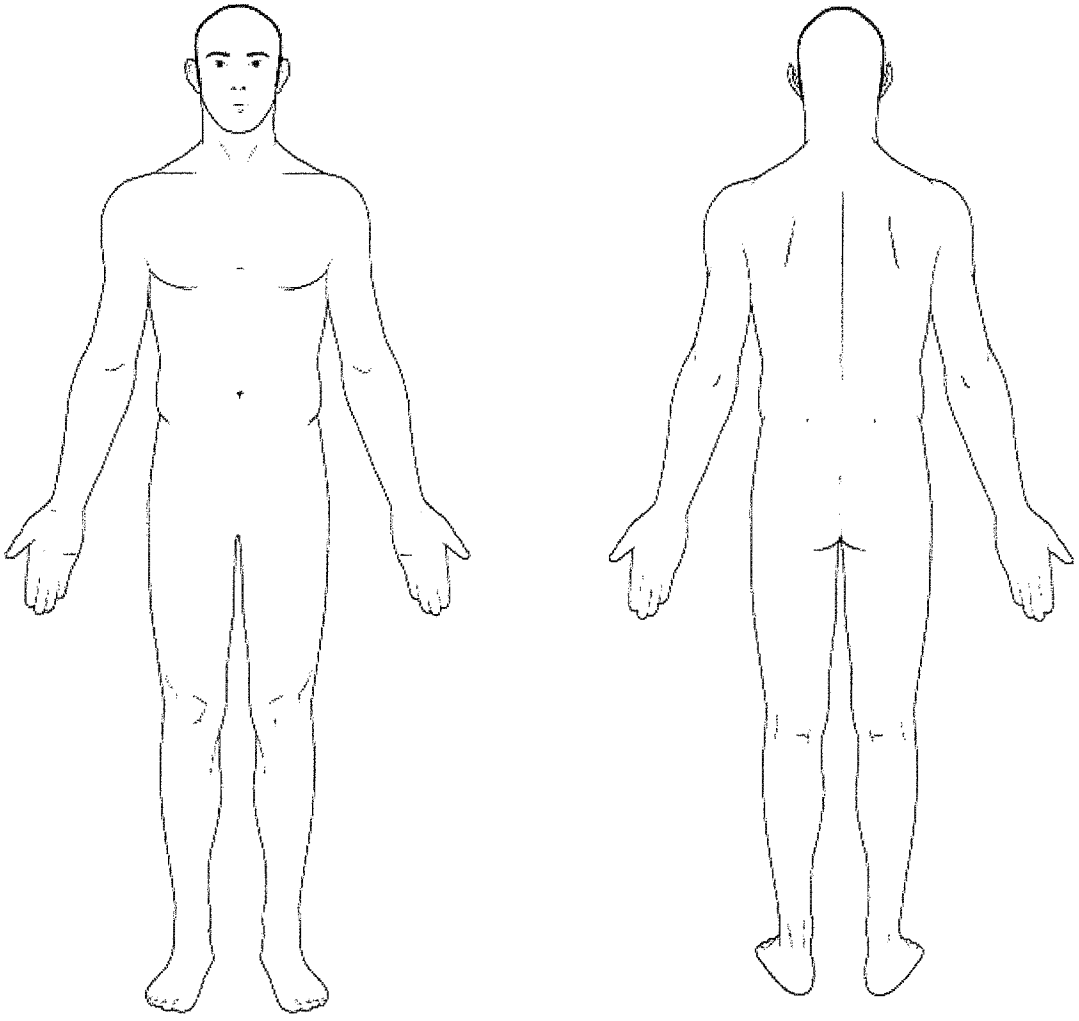

P = Pain N = Numbness T = Tingling B = Burning C = Cramping

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

- [ ] Are you left or right handed? Right Left
- [ ] Have you had a head injury? YES NO
- [ ] Do you currently experience or have a past history of vertigo or balance disorders? YES NO
- [ ] Do you have any ringing or pressure in the ears? YES NO
- [ ] Do you experience nausea? YES NO
- [ ] Do you find that your balance is getting worse? YES NO
- [ ] Do you have difficulties walking down stairs? YES NO
- [ ] Do you have difficulty with math problems, or remembering numbers? YES NO
- [ ] Do you find yourself searching for words frequently when you speak? YES NO
- [ ] Have you noticed your ability to concentrate is getting worse? YES NO
- [ ] Do you get lost often or have a hard time with directions? YES NO
- [ ] Do quick flashes of light on TV or loud noises bother you? YES NO
- [ ] Do you feel like you need to wear sunglasses outside? YES NO
- [ ] Has your handwriting changed in recent years? YES NO
- [ ] Do you have a hard time swallowing? YES NO
- [ ] Do you gag easily? YES NO
- [ ] Do you experience blurriness in your vision or double vision? ← (CIRCLE) YES NO
- [ ] Do you have any changes in smell or smell foul things that are not present? YES NO
- [ ] Do you have any difficulty with taste or taste things differently than what you are eating? YES NO
- [ ] Noticed clumsiness in hand coordination? Which hand? Right / Left ← (CIRCLE) YES NO
- [ ] Do you have difficulty with short-term memory? YES NO
- [ ] Have you been told or noticed any memory loss of past events? YES NO
- [ ] Noticed uneven sweating or temperature on one side of your body? YES NO
- [ ] Do you have any tightness, weakness or instability in your back or neck? ← (CIRCLE) YES NO
- [ ] Do you have tightness, or feelings of weakness in your hands or legs? ← (CIRCLE) YES NO
- [ ] Do you ever have any numbness or tingling in your hands, legs, or face? ← (CIRCLE) YES NO
- [ ] Do you have any difficulty with falling asleep or staying asleep? YES NO
- [ ] Do you get motion sickness easily (car sick or sea sick)? YES NO
- [ ] Do you ever experience flashes of light in your visual field? YES NO
- [ ] Do you ever experience dry eyes or mouth? ← (CIRCLE) YES NO
- [ ] Do you ever experience increase tearing or salivation? ← (CIRCLE) YES NO
- [ ] Do you ever have slurred speech? YES NO
- [ ] Noticed any drooping of your eyelids or facial muscles? ← (CIRCLE) YES NO
- [ ] Do you ever notice increased heart rate (tachycardia)or pulse during the day? YES NO
- [ ] Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? YES NO
- [ ] Do you experience Déjà Vu? YES NO
- [ ] Does driving cause you fatigue, headaches, or any other symptoms? ← (CIRCLE) YES NO
- [ ] Does working on a computer cause you fatigue, headaches or other symptoms? YES NO
- [ ] Have you lost your interest in hobbies and functions that you used to enjoy? YES NO
- [ ] Do you have a hard time motivating yourself to engage in activities? YES NO
- [ ] Do you ever have fluttering of the eye or noticed you are blinking frequently? YES NO
- [ ] Do you have difficulty distinguishing right and left? YES NO

Regenerative Medicine of Southern Indiana

3131 Newton St. Jasper, IN 47546

Name:_____ Date:_____

Instructions: Please rate the activities in each category according to the following scale difficulty:

0= None 1= Slight 2= Moderate 3= Very 4=Extremely

Circle **one number** for each activity.

Pain

1.	Walking	0	1	2	3	4
2.	Stair Climbing	0	1	2	3	4
3.	Nocturnal	0	1	2	3	4
4.	Rest	0	1	2	3	4
5.	Weight Bearing	0	1	2	3	4

Stiffness

1.	Morning Stiffness	0	1	2	3	4
2.	Stiffness occurring later in day	0	1	2	3	4

Physical Function

1.	Descending Stairs	0	1	2	3	4
2.	Ascending Stairs	0	1	2	3	4
3.	Rising from sitting	0	1	2	3	4
4.	Standing	0	1	2	3	4
5.	Bending to floor	0	1	2	3	4
6.	Walking on flat surface	0	1	2	3	4
7.	Getting in/out of car	0	1	2	3	4
8.	Going shopping	0	1	2	3	4
9.	Putting on socks	0	1	2	3	4
10.	Lying in bed	0	1	2	3	4
11.	Taking off Socks	0	1	2	3	4
12.	Rising from bed	0	1	2	3	4
13.	Getting in/out of bath	0	1	2	3	4
14.	Sitting	0	1	2	3	4
15.	Getting on/off toilet	0	1	2	3	4
16.	Heavy domestic duties	0	1	2	3	4
17.	Light domestic duties	0	1	2	3	4

Total Score: _____/96=_____%

Regenerative Medicine
3131 Newton St. Ste #2 • Jasper, IN 47546 • (812) 482-4005

Privacy Authorization for Regenerative Medicine

Dr. Riecker and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This Notice is effective as of April 14, 2003. This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner described. I also acknowledge that I have read and received a copy of the Riecker Chiropractic's Privacy Policy.

Patient Signature_____ Date_____