BALANCE
REGENERATIVE MEDICINE

NEW PATIENT INTAKE

Name :_____ Age: _____DOB:_____ Sex: _____ Email:_____

Address:_____City:_____State:_____Zip:_____ Cell Phone: (____) _____-_____

Alternate Phone:(____) _____-_____ May we leave detailed messages on phone/email? Yes /No Ht: _____ Wt: _____

Occupation:_____ Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Emergency Contact:_____Relationship to patient: _____ Phone: (____) _____-_____

CHECK ALL THAT APPLY: Balance Regenerative Medicine may contact me by: ( ) email ( ) text and may send me:
( ) appointment reminders ( ) personalized treatment recommendations ( ) occasional special offers or discounts

How did you hear about us? _____

Primary Care Provider_____ @Practice Name: _____

Practice Address: _____ Practice Phone: (____) _____-_____ Fax: (____) _____-_____

Preferred Pharmacy/Location_____ Phone: (____) _____-_____ Fax: (____) _____-_____

PRIORITY HEALTH CONCERNS:

Please list the top 6 major health concerns which brought you to Balance Regenerative Medicine in order of importance:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL HISTORY:

Please list any conditions you have been previously diagnosed with by another provider & date diagnosed if known:

1. _____Mo/Yr:_____ 6. _____Mo/Yr:_____
2. _____Mo/Yr:_____ 7. _____Mo/Yr:_____
3. _____Mo/Yr:_____ 8. _____Mo/Yr:_____
4. _____Mo/Yr:_____ 9. _____Mo/Yr:_____
5. _____Mo/Yr:_____ 10. _____Mo/Yr:_____

SURGERIES:

Please list ALL surgeries you've had (include C-sections, Cosmetic, Outpatient, Dental, etc) & date of surgery if known:

1._____Mo/Yr:_____ 4. _____Mo/Yr:_____
2._____Mo/Yr:_____ 5. _____Mo/Yr:_____
3._____Mo/Yr:_____ 6. _____Mo/Yr:_____

PAIN:

Do you have pain? Yes/No If yes, location(s): _____

Rate 1-10_____ Pain quality: ( ) sharp ( ) dull ( ) radiating ( ) throbbing ( ) cramping ( ) chronic ( ) acute

Other_____

SLEEP:

Do you sleep well? Yes/No How many hours per night? _____ Do you nap? Yes/No Have you ever had a sleep study? Yes/No

CHECK ANY WHICH APPLY TO YOUR SLEEP PATTERN: ( ) Difficulty falling asleep ( )Awakening intermittently during the night ( )Excessive Daytime Sleepiness ( )Snoring, ( ) Irregular Breathing While Sleeping ( ) Gasping for Air While Sleeping ( ) Diagnosed Obstructive Sleep Apnea ( ) Use CPAP regularly ( ) CPAP but don't use as prescribed ( ) O2 when Sleeping

If you awaken at night what awakens you? _____

MEDICATION/SUPPLEMENT/ALLERGY LIST

MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
SUPPLEMENTS	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES: (Include: Drugs, Foods, Environmental)

No Known Drug Allergies

1. _____Reaction:_____ 4. _____Reaction:_____

2. _____Reaction:_____ 5. _____Reaction:_____

3. _____Reaction:_____ 6. _____Reaction:_____

TOXIC EXPOSURE: Check any you have come in contact with: ( )Mercury fillings ( ) Artificial Joints or Implants ( )Lead ( ) Arsenic ( ) Radon ( ) Cadmium ( ) Aluminum ( ) Mercury ( ) Oil ( ) Mold ( ) Industrial Chemicals ( ) Roundup ( ) Welding ( ) Mechanical Chemicals ( ) Taxidermy ( ) Pesticides ( ) Herbicides ( ) Construction ( ) Radiation
Excessive exposure at home or at work, to hazardous waste mold or chemicals. Yes/No Type(s):_____

SOCIAL HISTORY:

Use of Alcohol: ( ) Never ( ) 1-5 drinks weekly ( ) Daily ( ) >15 drinks/weekly ( ) Social Previously:Date quit:_____
Total length of use (years)_____Type(s) of Alcohol:_____

Use of Tobacco/Cigarettes: ( ) Never ( ) Current ( ) Previously:Date quit:_____ Total length of use (years)_____
Packs per day:_____ Type(s) of Tobacco:_____

Use of Illicit Drugs: ( ) Never ( ) Occasional ( ) Regular Type(s):_____ Date last used: _____

Use of Diet Drugs: ( ) Never ( ) Occasional ( ) Regular Type(s):_____Date last used: _____

FAMILY MEDICAL HISTORY:

FAMILY MEMBERS	LIVING?	AGE OR AGE AT DEATH	DISEASE(S)	CAUSE OF DEATH
Father				
Mother				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				
Uncle/Aunt Maternal				
Grandmother Maternal				
Grandfather Maternal				
Aunt/Uncle Paternal				
Grandmother Paternal				
Grandfather Paternal				
First Cousin				
First Cousin				

PATIENT MEDICAL HISTORY:

COVID-19 Infection	Yes	No	Skin Conditions	Yes	No
Diabetes	Yes	No	Hereditary Defects	Yes	No
Bleeding Disorders	Yes	No	Clotting Disorders	Yes	No
Kidney Disease	Yes	No	Liver Disease	Yes	No
Hypertension	Yes	No	Low or High Blood Cell Count	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No
Stroke/TIA	Yes	No	Reflux/Heartburn	Yes	No
Heart Problems	Yes	No	Thyroid disease	Yes	No
Respiratory Problems	Yes	No	Gastrointestinal Conditions	Yes	No
Asthma or Allergies	Yes	No	Genitourinary Conditions	Yes	No
Heart Attack	Yes	No	Autoimmune Conditions	Yes	No
Arthritis/Gout	Yes	No	Mental Health Issues	Yes	No
Seizure	Yes	No	Kidney Stones	Yes	No
Joint Problems	Yes	No	Numbness/Tingling	Yes	No
Chronic Infection	Yes	No	Neurological Conditions	Yes	No
Acute Infection	Yes	No	Migraines	Yes	No
STD's	Yes	No	Eyes, Ears, Nose, Throat Condition	Yes	No

Please Provide Details for any **Yes** Answers Above:

_____

_____

_____

Provider Notes:

_____

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REVIEW OF SYMPTOMS:

Constitutional Symptoms			**Musculoskeletal**		
Good General Health	Yes	No	Joint Pain	Yes	No
Recent Weight Change Weight Loss pounds: Weight gain pounds:	Yes	No	Joint stiffness or swelling	Yes	No
Fever	Yes	No	Weakness of muscle or joints	Yes	No
Fatigue	Yes	No	Back Pain	Yes	No
Headaches	Yes	No	Cold Extremities	Yes	No
Night sweats	Yes	No	Injury-Type:	Yes	No
Eyes			Difficulty walking	Yes	No
Eye disease or injury	Yes	No	**Integumentary**		
Wear glasses/contacts	Yes	No	Rash, itching or Urticaria	Yes	No
Blurred/Double Vision	Yes	No	Change in skin Color	Yes	No
Glaucoma	Yes	No	Change in hair or nails	Yes	No
Eye pain / redness or Abnormal discharge	Yes	No	Change in mole/warts	Yes	No
Sudden Change in Vision	Yes	No	Difficulty with healing cuts	Yes	No
Ears/Nose/Mouth/Throat			Varicose veins	Yes	No
Hearing loss or ringing	Yes	No	Eczema	Yes	No
Ear ache or Drainage	Yes	No	Psoriasis	Yes	No
Chronic sinus Problems	Yes	No	**Neurological**		
Nose Bleeds	Yes	No	Paralysis	Yes	No
Post Nasal Drainage	Yes	No	Weakness	Yes	No
Recurrent Strep Infection	Yes	No	Migraines	Yes	No
Enlarged Tonsils	Yes	No	Nerve Pain	Yes	No
Mouth sores	Yes	No	Freq/recurring headaches	Yes	No
Bleeding gums	Yes	No	Lightheaded/Dizzy or Vertigo	Yes	No
Bad Breath or Bad Taste	Yes	No	Seizure	Yes	No
Sore Throat or Voice change	Yes	No	Numbness/tingling sensation Location(s)	Yes	No
Swollen Glands in neck	Yes	No	Tremors: Intermittent/Constant	Yes	No
Cardiovascular			Memory Loss	Yes	No
High Blood Pressure	Yes	No	Acute Head injury/Concussion	Yes	No
Chest Pain or Angina	Yes	No	**Psychiatric**		
Rapid heart rate	Yes	No	Bipolar	Yes	No
Shortness of breath Cough at night	Yes	No	Memory Loss/confusion	Yes	No
Swelling of feet, ankle, or hands	Yes	No	Nervousness	Yes	No
Respiratory			Depression	Yes	No
Chronic cough	Yes	No	Insomnia	Yes	No
Coughing up blood	Yes	No	Anxiety	Yes	No
Shortness of breath	Yes	No	Post Traumatic Stress Disorder	Yes	No
Pain with breathing	Yes	No	**Endocrine**		
Asthma or wheezing	Yes	No	Known Endocrine Condition Type:	Yes	No
Gastrointestinal			Thyroid Disease: Hypo / Hyper	Yes	No
Loss of Appetite	Yes	No	Awaken @ night with no known cause	Yes	No
Increase in appetite	Yes	No	Excessive thirst	Yes	No
Change in Bowel Movements	Yes	No	Excessive urination	Yes	No
Nausea and/or vomiting	Yes	No	Diabetes: Type 1 / Type 2	Yes	No

Painful Bowel Movements/constipation	Yes	No	Heat or cold Intolerance	Yes	No
Loose stools/diarrhea Number of stools per day:	Yes	No	Shakiness and trembling	Yes	No
Rectal Bleeding or Blood in stool	Yes	No	Pain in joints/muscles late in day	Yes	No
Heartburn/reflux	Yes	No	Hypoglycemia	Yes	No
Abdominal pain	Yes	No	Excessive drowsiness after eating	Yes	No
Ulcer (stomach or Duodenal)	Yes	No	**Blood/Lymph Abnormalities**		
Gas, Bloating	Yes	No	Slow to heal after cuts /injuries	Yes	No
Malabsorption	Yes	No	Enlarged Lymph Nodes	Yes	No
Food Intolerance	Yes	No	Symptoms of Blood Clot	Yes	No
Genitourinary			Bleeding or Bruising tendency	Yes	No
Frequent Urination	Yes	No	Anemia/Low Iron	Yes	No
Burning or painful Urination	Yes	No	Pain in Blood Vessel(s)	Yes	No
Discharge with Urination			Too Much Iron in Blood	Yes	No
Blood in urine	Yes	No	Past BloodTransfusion	Yes	No
Change in stream or strain with urination	Yes	No	New Mass or Swelling	Yes	No
Incontinence or dribbling	Yes	No	Frequent Illnesses (Viral or Bacterial)	Yes	No
Recurrent UTI or Kidney Infection	Yes	No	Immunodeficiency	Yes	No
Kidney Disease/Failure	Yes	No	Blood Disorder	Yes	No
Other			**Other**		
	Yes	No		Yes	No
	Yes	No		Yes	No
	Yes	No		Yes	No
	Yes	No		Yes	No

Please Provide Details for any **Yes** Answers Above:

_____

_____

_____

Provider Notes:

_____

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_____

_____

LABS/DIAGNOSTICS/VACCINATIONS:

PROCEDURE	DATE (MONTH/YR)	RESULTS NORMAL?	FACILITY
Full Blood Test Panels		Yes/No	
EKG		Yes/No	
Chest X-ray		Yes/No	
Colonoscopy		Yes/No	
Mammogram		Yes/No	
Pap Smear		Yes/No	
Bone Density/Dexa Scan		Yes/No	
CT scan or MRI scan		Yes/No	
Ultrasound(s)		Yes/No	
VACCINE	DATE (MONTH/YR)	DUE FOR BOOSTER?	FACILITY
Flu Vaccine		Yes/No	
Pneumonia Vaccine		Yes/No	
Shingles Vaccine		Yes/No	
Tetanus Vaccine		Yes/No	
COVID-19 Vaccine		Yes/No	
Other			