McLaughlin Cell Therapies

a non-surgical approach to joint and back pain

**Please PRINT and fill out completely.**

Date: ____/_____/_____

Name: _____ DOB:_____ Age:_____

Height _____ft. _____in. Weight_____lbs Sex:_____ Are you or could you be pregnant?_____

Your Occupation:_____ Employer:_____

Who referred you to this office? O Dr._____ O PA/NP _____

O Family/Friend _____ O Physical Therapist _____

O Other _____

Pharmacy Name and Location: _____

## HISTORY OF CARE

Who is your primary care physician? _____ Location: _____

Address: _____ Phone: _____

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name: City: Date of First Visit: Currently Continuing?:

_____

_____

_____

_____

## HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:

1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:

_____

_____

_____

_____

Is there current imaging available (i.e. MRI, CT) regarding this current spinal condition? _____

If so, at what facility was this performed? _____

Please bring a copy (CD or films) of your imaging to your appointment.

## CURRENT SYMPTOMS

What time of day is your pain at its worst? O Morning O Afternoon O Evening O Night O N/A

Does the pain wake you up at night? O Yes O No

In the past six months have you experienced: O Fever O Weight Loss _____lbs

O Chills O Night Sweats

How would you describe your pain? O Constant O Constant, but worse with activity

O Intermittent (comes and goes)

O Intermittent, but worse with activity

Do you have full control of your bladder? O Yes O No

Do you have full control of your bowels? O Yes O No

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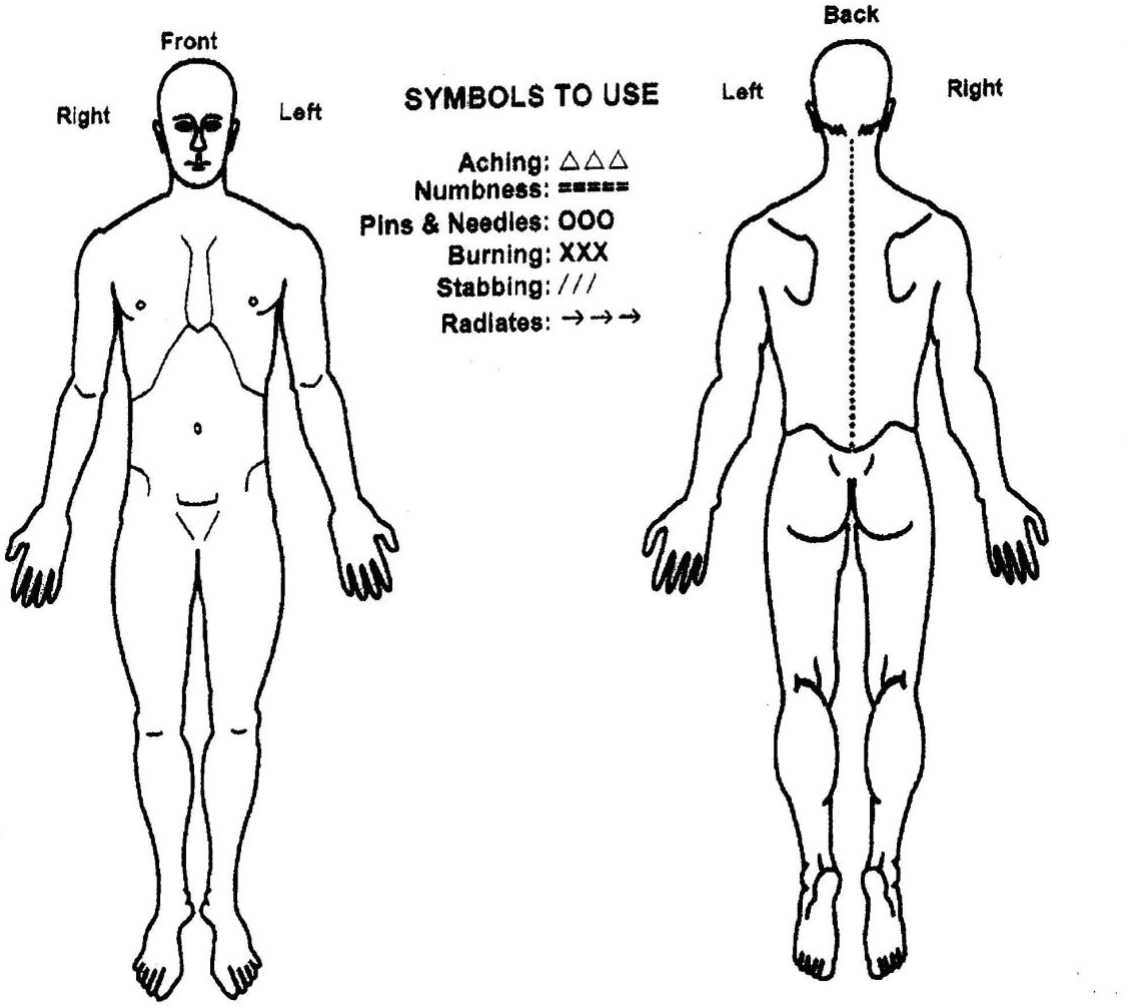
## PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, including all affected areas.




Mark where any symptoms (pain, numbness, weakness, etc) exist on average (most of the time) and at their worst.

Current pain:

| | None | | | | | | | | | | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Average | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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## MEDICAL HISTORY

Check if you are being treated for or have been diagnosed with:

| | When? | | When? |
|---|---|---|---|
| O High Blood Pressure | _____ | O Osteoporosis | _____ |
| O Diabetes | _____ | O Kidney Disease/Problem | _____ |
| O Liver Disease | _____ | O Seizures | _____ |
| O Heart Disease or Attack | _____ | O Arthritis | _____ |
| O Stroke | _____ | O Thyroid | _____ |
| O Cancer | _____ | O Tuberculosis | _____ |
| O High Cholesterol | _____ | O Psoriasis | _____ |
| O Ulcer Disease | _____ | O Polio | _____ |
| O Gastritis | _____ | O Rheumatic Fever | _____ |
| O Reflux Disease (GERD) | _____ | O Gout | _____ |
| O Asthma | _____ | O Herpes Simplex | _____ |
| O Depression | _____ | O Bipolar Disease | _____ |
| O Other Psychiatric | _____ | O *Pacemaker/ *Stent(s) | * PLEASE PROVIDE CARD |

Have you ever had a history of blood clots or pulmonary embolus? O Yes O No

## SURGERIES

Please list all spine surgeries you have had in the past:

Type of Surgery: Date: Surgeon:

_____

_____

_____

_____

Please list all other surgeries you have had in the past:

Type of Surgery: Date: Surgeon:

_____

_____

_____

_____

## MEDICATIONS

Please list ALL medications you are <u>currently</u> taking, including prescription and over the counter:

Medication: Dosage: Frequency: (how many pills in 24 hours)

_____

_____

_____

_____

## ALLERGIES

Please list any allergies or adverse reactions you have to medications:

Medication: What Happened?:

_____

_____

_____

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