SUMMIT
REGENERATIVE
HEALTH

Samuel Gray DC **Leonard Weinberger MSN-FNP**

All no call/no show appointments without a 24 notice to reschedule or cancel will be subject to a $75 Cancellation Fee.

New Patient Questionnaire

Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Date Of Birth: _____ Age: _____ SSN: _____ Sex: ☐ M ☐ F

Street Address: _____ City: _____ Zip: _____

Home Phone #: _____Cell Phone #: _____Work Phone #: _____

Email Address: _____

Insurance Information

Primary Ins: _____ Sub/Contract ID#: _____

Group #: _____ Policy Holder Name: _____ Birth Date: _____

Secondary Ins: _____ Sub/Contract ID#: _____

Group #: _____ Policy Holder Name: _____ Birth Date: _____

Does your insurance require:

Pre-Authorization? ☐ Y ☐ N

Referral from your PCP? ☐ Y ☐ N

If yes to the 2 above questions, did you bring a copy of your referral with you? ☐ Y ☐ N

Referring Physician: _____ Phone #: _____

Address: _____

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Who is your PCP?: _____ Phone #: _____

Address of your PCP?: _____

Pain History

How would you rate your overall satisfaction with the treatments you have received for pain to the present?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Barely Satisfied

☐ Dissatisfied ☐ Very Dissatisfied

A.) Where is your pain located?: _____

B.) When did your pain begin? _____

C.) Did your pain begin… ☐ Gradually? and or ☐ Suddenly?

D.) Under what circumstances did your pain begin?

☐ Accident at work ☐ Accident at home ☐ At work, but not an accident

☐ Other accident ☐ Following an illness ☐ Following surgery

☐ Pain just began, can't relate to anything ☐ Other:

_____

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Past Medical History

(Please circle all that apply down below)

Cardiovascular pain/Angina
☐ None ☐ Heart Attack ☐ Chest
☐ Heart Failure ☐ High Blood Pres. ☐ Arrhythmia
☐ Other:
_____

Circulation
☐ None ☐ Blood Clots ☐ Phlebitis
☐ Swelling ☐ Blockage ☐ Bleeding trend
☐ Other: _____

Respiratory
☐ None ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Shortness of Breath ☐ COPD/Emphysema
☐ Other: _____

Gastrointestinal
☐ None ☐ Ulcers ☐ Nausea/Vomiting
☐ Diarrhea ☐ Constipation ☐ Hepatitis
☐ Other: _____

Urinary
☐ None ☐ Kidney Failure ☐ Kidney Infection
☐ Kidney Stones ☐ Bladder Infection ☐ UTI
☐ Other: _____

Neurological
☐ None ☐ Seizures ☐ TIA/Stroke
☐ Paralysis ☐ Numbness ☐ Head Injury
☐ Other: _____

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Musculoskeletal	☐ None	☐ Weakness	☐ Pinched Nerve
	☐ Arthritis	☐ Joint Pain	☐ Muscle Pain
	☐ Other: _____		
Endocrine/Meta-Bolism	☐ None	☐ Diabetes	☐ Insulin Dependency
	☐ Hypoglycemia	☐ Hyperglycemia	☐ Thyroid
	☐ Other: _____		
Other	☐ Alcohol Abuse	☐ Drug Abuse	☐ Anxiety

Surgical History

List Surgical procedure, and the year performed below.

Medications

List all medications, including any over the counter and prescription pain medication. Please include the dosage and frequency as well.

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Medication Allergies

(List each medication along with the reaction associated with the medication)

Pain Medication History

Pain medication and dose in the past	Amount of pain relieved	Problems and or side effects?

Social History

Current Usage: ☐ Smoker ☐ Alcohol ☐ Illicit Drugs ☐ THC

Previous History: ☐ Smoker ☐ Alcohol ☐ Illicit Drugs ☐ THC

Treatment History

Have you ever had any of the following types of treatment for your pain, and what were the results?

Physical Therapy: Date Last Seen: _____ Name of Facility:_____ No. Of Visits?: ____

Passive ☐ Y ☐ N ☐ Improved ☐ No Change ☐ Worse
(Heat, gentle massage, ultrasound)

Mobilizations ☐ Y ☐ N ☐ Improved ☐ No Change ☐ Worse

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Exercises	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse

Chiropractic

Manipulation	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Modalities (Heat, ultrasound)	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse

Other

Deep Tissue Massage	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Acupuncture	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Trigger Point Injections	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
TENS	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Biofeedback	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Pain Management	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Epidural Steroid Injections	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
Nerve Blocks	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse
NSAIDS	☐	Y	☐	N	☐	Improved	☐	No Change	☐ Worse

Imaging

Have you had any of the following to investigate your pain problem?

☐ X-Ray ☐ MRI ☐ CAT Scan ☐ EMG
☐ Bone Scan ☐ Myelogram

Pain Modifiers

Please indicate if any of the following INCREASE or DECREASE your pain.

	Increase	Decrease		Increase	Decrease
Bright Lights	☐	☐	Mild Exercise	☐	☐
Cold	☐	☐	Coughing	☐	☐
Movement	☐	☐	No Movement	☐	☐

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Eating	☐	☐		Pressure	☐	☐	
Fatigue	☐	☐		Rest, Sleep	☐	☐	
Heat	☐	☐		Sitting	☐	☐	
Housework	☐	☐		Standing	☐	☐	
Loud Noises	☐	☐		Tension	☐	☐	
Lying Down	☐	☐		Urinating/BM	☐	☐	
Massage	☐	☐		Vigorous Exercise	☐	☐	
Walking	☐	☐		Weather Changes	☐	☐	
Work Related	☐	☐					

Employment

Are you currently employed?

☐ Yes, full time
☐ Yes, part time
☐ No, but not because of pain
☐ Retired
☐ Yes, full time with restrictions
☐ Yes, part time with restrictions
☐ No, unable to work due to pain

Litigation

Are you currently involved in a lawsuit because of your pain? ☐ Y ☐ N

Have you been involved in a legal suit in the past because of your pain? ☐ Y ☐ N

Are you planning on taking legal action because of your pain? ☐ Y ☐ N

Consent to Treat

(Please read THOROUGHLY before signing.)

I, _____ hereby give my informed consent for medical treatment and procedures to be administered by the healthcare professionals at Summit Regenerative Health.

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I understand that by signing this form, I am authorizing Summit Regenerative Health and its healthcare providers to provide medical treatment, conduct diagnostic tests, and perform necessary procedures to diagnose and treat my medical condition.

I understand that all medical treatments and procedures carry certain risks and potential benefits. While Summit Regenerative Health will take necessary precautions to minimize risks, I acknowledge that no guarantees or assurances can be made regarding the outcome of any treatment or procedure.

I understand the importance of open and honest communication with my healthcare provider. I agree to provide accurate and complete information about my medical history, current medications, allergies, and other relevant details. I understand I should follow any post-treatment instructions and attend follow-up appointments as recommended.

I understand that I am financially responsible for **all** medical services rendered by Summit Regenerative Health. I agree to pay **all** charges for services not covered by my insurance, including deductibles, co-pays, and any outstanding balances.

I have read and understood the contents of this Medical Consent Form, and I voluntarily consent to receive medical treatment and procedures from Summit Regenerative Health.

Name: _____ Signature: _____ Date: _____