GOLD COAST
REGENERATIVE
MEDICINE

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

Phone # (H)_____ (C) _____ (W) _____

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

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

Occupation _____ Employer_____

Emergency contact: Name: _____ Relation: _____

Phone # :(H) _____(C) _____

How did you hear about our practice**?** _____

Insurance Information

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Policy Holder Name: _____D.O.B._____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Flagship Healthcare. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of 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 and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

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.

X_____ _____

Signature of Patient/Guardian Date

NAME: _____DOB:_____ Age: _____ Date of Exam: _____

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
- ☐ Autism
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cataracts
- ☐ Chemical Dependency ☐ Bulimia
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Vitamin D deficiency
- ☐ Food cravings
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Loss of Memory
- ☐ Measles
- ☐ Mononucleosis
- ☐ Nausea
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Sinus
- ☐ Skin Rashes
- ☐ Skin burns/wounds
- ☐ Sagging/aging skin
- ☐ Tuberculosis
- ☐ Tumors/Growths

Please list all medical conditions **NOT** Listed elsewhere on this form:

_____

_____

_____

_____

_____

_____

Metabolic/Nutritional

- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Weight gain
- ☐ Cold Sores
- ☐ Bleeding Disorders
- ☐ Constipation
- ☐ Blurred Vision
- ☐ Bowel/Bladder Changes
- ☐ Cold Feet/Hands
- ☐ Dizziness
- ☐ Fatigue
- ☐ Goiter
- ☐ Abdominal Pain
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches
- ☐ Insomnia
- ☐ Liver Disease
- ☐ Light Bothers Eyes
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Sleeping Difficulties
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ Sudden Weight Loss

Physical

- ☐ Arthritis
- ☐ Neck Pain/Stiffness
- ☐ Mid Back pain/stiffness
- ☐ Low Back pain/stiffness
- ☐ Sciatica
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot pain
- ☐ Numbness/tingling
- ☐ Wrist pain
- ☐ Shoulder pain
- ☐ Plantar Fasciitis

Hormonal

- ☐ Depression
- ☐ Low Body Temp
- ☐ Migraines
- ☐ Acne
- ☐ Miscarriage
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Prostate Problems
- ☐ Breast Lump
- ☐ Suicide Attempt
- ☐ Vaginal Infections
- ☐ Low libido
- ☐ Female Incontinence
- ☐ Thyroid Problems
- ☐ Sexual Sensitivity
- ☐ Erectile Dysfunction

Cardiology

- ☐ Ankle Swelling
- ☐ Arm/Hand Pain
- ☐ Cold Sweats
- ☐ Chest Pain
- ☐ Fainting
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Stroke
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Carotid artery blockage
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Low magnesium
- ☐ Low potassium

- ☐ PCOS
- ☐ Fibroids
- ☐ Breast Cancer
- ☐ Prostate cancer
- ☐ Triglycerides >300

☐ Cancer type_____ when diagnosed: _____ remission: _____

Initial Intake

NAME: _____

Is it easy for you to give blood? Y N If no please explain _____

Are you currently under drug and/or medical care? □ Yes □ No Who is your primary care Dr? _____

Please all medications: (**Be sure to include dosage and frequency**)_____

_____

Are you on any anti-inflammatory meds? (Aleve, Naproxen, Motrin, Ibuprofen, Celebrex, Meloxicam, Mobic, Voltaren, Diclofenac)

Other:

_____

Do you take blood thinners (Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Pradaxa)? _____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

WOMEN ONLY: Date of LMP: _____ ***Any possibility of pregnancy: YES or NO***

Surgical History: (Please note ALL joint replacement surgeries!)

Surgeries and/or hospitalizations (**type & date**): _____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

□ Heart Disease_____ □ Diabetes _____
□ Cancer _____ □ Arthritis _____ □ Other _____

Social History:
Intake of following: Cigarettes _____ packs/day Alcohol _____drinks/week Caffeine _____ cups/day

Exercise frequency: □ Never □ Daily □ Weekly □ Walks □ Runs □ Swims

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 cancers, 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: X_____I have read and understand the above consent form.

CHIEF COMPLAINT:

HOW WOULD YOU RATE YOUR SYMPTOMS: (10 IS THE WORST)

WHEN DID THIS BEGIN?

WHAT MAKES IT BETTER?

WHAT MAKES IT WORSE?

HOW WOULD YOU DESCRIBE YOUR SYPMTOMS?

☐ STABBING /SHARP ☐ ELECTRIC-SHOCK ☐ COLD ☐ TINGLING ☐ SWELLING ☐ BURNING

☐ STINGS ☐ ACHE ☐ NUMBNESS ☐ TIREDNESS ☐ CRAMPING

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING?

☐ SLEEP ☐ WORK ☐ DAILY ROUTINE ☐ SHOPPING ☐ CHORES ☐ WALKING ☐ STANDING

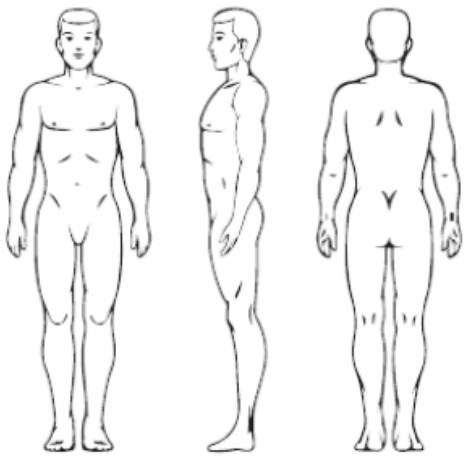
HOW WOULD YOU RATE YOUR AVERAGE CONDITION OVER THE PAST WEEK?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

PLEASE INDICATE WHAT YOU CONSIDER TO BE AN ACCEPTABLE LEVEL OF PAIN AFTER COMPLETION OF THE TREATMENT, IF YOU HAVE TO ACCEPT SOME PAIN?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

PLEASE INCIDATE ON THESE DRAWINGS THE BODY AREA(S) WHERE YOU ARE CURRENTLY EXPERIENCING SYMPTOMS:
USE THE FOLLOWING:
PAIN= P NUMBNESS/TINGLING = NT STIFFNESS = S



OTHER PROBLEMS IN ORDER OF IMPORTANCE	HOW LONG
1.	1.
2.	2.
3.	3.
4.	4.

QUALITY OF LIFE SURVEY

Name: _____ Date: _____

1. How have you taken care of your health in the past?
a) Medications
b) Emergency Room
c) Routine Medical
d) Exercise
e) Nutrition/ diet
f) Holistic Care
g) Vitamins
h) Chiropractic
i) Other please specify _____

2. How did the previous method(s) work out for you?
a) Bad results
b) Some results
c) Great results
d) Nothing changed
e) Did not get worse
f) Did not work very long
g) Still trying
h) Confused

3. How have others been affected by your health condition?
a) No one is affected
b) Haven't noticed any problem
c) They tell me to do something
d) People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
a) Job
b) Kids
c) Future ability
d) Marriage
e) Self esteem
f) Sleep
g) Time
h) Finances
i) Freedom

5. Are there health conditions you are afraid this might turn into?

a) Family health problems
b) Heart disease
c) Cancer
d) Diabetes
e) Arthritis
f) Fibromyalgia
g) Depression
h) Chronic fatigue
i) Need surgery

6. How has your health condition affected your job, relationship, finances, family or other activities? Please give examples:

_____
_____
_____
_____

7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

1. _____
_____
2._____
_____
3._____
_____

8.What are you most concerned about regarding your problem?

_____
_____
_____

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

_____
_____
_____

10. What would be different /better without this problem? Please be specific

_____
_____
_____

11. What do you desire most to get from working with us?

_____
_____
_____

12. What would that mean to you?

_____
_____
_____
_____

GOLD COAST REGENERATIVE MEDICINE

Name:_____ Date:_____

Walking Scale Questionnaire

These questions ask about limitations to you walking during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question.

In the past 2 weeks, how much has your pain/discomfort …	Not at all	A little	Moderately	Quite a bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up or down stairs?	1	2	3	4	5
Made standing when doing things more difficult?	1	2	3	4	5
Limited your balance when standing or walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors (e.g. holding on to furniture, using a cane, etc.)?	1	2	3	4	5
Made it necessary for you to use support when walking outdoors (e.g. using a cane, walker, etc.)?	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

WALKING SCALE DISABILITY SCORE: <12 NORMAL, 13-27 MILD, 28-45 MODERATE,>46 SEVERE DISABILITY

GOLD COAST REGENERATIVE MEDICINE

Gut Inflammation Evaluation

Name_____ Date_____

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz below to help evaluate how we can help your condition and any underlying triggers limiting your health.

Please circle any that apply to you prior to taking the quiz below:

Headaches	Migraines	PMS	Emotional imbalance
Abdominal bloating	Abdominal cramps	Bloating	Painful gas
Irritable Bowel Syndrome	Ulcerative Colitis	Crohn's Disease	Intestinal Disorders
Chronic Sinusitis	Asthma	Allergies	Diabetes
Lupus	Rheumatoid Arthritis	Fibromyalgia	Chronic Fatigue
Autism	ADD/ADHD	Eczema	Skin rashes
Hives			

Circle the number that most closely fits	None	Mild	Moderate	Severe
Constipation and/ or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies , sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammation	0	1	2	3
Eczema, skin rashes or hives	0	1	2	3
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion , poor memory or mood swings	0	1	2	3
Use of NSAIDS (aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight trouble	0	1	2	3

Total _____