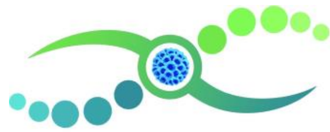

STEM CELL Therapy of Arizona

First Name: ______________________ **Last Name:** ______________________

Sex: (circle one) Male Female **DOB:**____________ **Height:** ______ **ft.** ______ **in.**

Current Weight: ______ **lbs.** **E-mail:** ______________________

Address: ______________________

City: ______________ **State:** ________ **ZipCode:** ______________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

PLEASE ANSWER THE FOLLOWING

What is your area of greatest pain? ______________________

What other areas of your body give you pain? ______________________

Have you been given a diagnosis in the past? YES _____ NO _____ If yes, what was it? ______________________

Please check the box if you have or have had any of the below:

- ☐ Cancer

Bleeding Disorders:
- ☐ Septicemia
- ☐ Platelet Dysfunction Syndrome
- ☐ Hemodynamic Instability
- ☐ Anemia

Infection/Immune:
- ☐ Recent Fever or Illness
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Other Immune Disorders

GI Conditions:
- ☐ GERD
- ☐ Ulcer
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Other Digestive Problems

Nervous System:
- ☐ Migraine
- ☐ Tension/Headaches
- ☐ Bipolar
- ☐ Sleeping Disorders
- ☐ CTS
- ☐ Neuromuscular Disease

Cardio Vascular:
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Pulmonary/Lung Disease
- ☐ COPD
- ☐ Stroke

Muscular Skeletel:
- ☐ Neck Pain
- ☐ Shoulder/Hip/Knee Pain
- ☐ Arthritis
- ☐ Back Pain
- ☐ Hand/Feet Pain
- ☐ Numbness in Hands/Feet

Which of the above bothers you the most? ______________________

How long have you had it? ____________ How often does it occur? ____________

What activities would you like to do if this was not a problem? ______________________

Medications:
☐ NSAID ☐ Opiate ☐ Aspirin/Blood Thinners ☐ Steroid Injections ☐ High Blood Pressure ☐ Diabetes ☐ Thyroid

List of Medications and Supplements:(list on back if needed): ______________________

Do you have a known drug allergy?______________________

Patient Signature: ______________________ Date: ____________

Provider Signature: ______________________ Date: ____________