Medical History and Intake Form

Regenerative Medicine & Therapy - Ozone, Exosome, PRP, Float Pod, Sauna

Patient Name: ____ DOB: _________________________

Email:____ Phone: _________________________________

Check appropriate Boxes**:** ☐Male ☐Female ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address: ____ City: ______________________ State: _____

Zip: _______________

Occupation:____

How did you hear about us? (please be as specific as possible) ____

Person to contact in case of an emergency: _________________________________ Relationship: _______________

Phone: ____________

Healthcare Providers you see and for what reason:____

____

Please list the primary reason for visit/treatment today and what you hope to treat:

____

Medical diagnoses:

Arthritis	NO / YES	Chronic Fatigue Syndrome	NO / YES	Liver disease	NO / YES
Osteo/Rheumatoid/Psoriatic		COPD	NO / YES	Lyme/co-infection	NO / YES
Autoimmune Disease	NO / YES	Chron's/Ulcerative Colitis	NO / YES	Mental health/Mood disorder	NO / YES
CMV	NO / YES	Multiple Sclerosis	NO / YES	Diabetes	NO / YES
Neurologic condition	NO / YES	Anemia	NO / YES	EBV/Mono	NO / YES
Pain – Chronic	NO / YES	Asthma	NO / YES	Fibromyalgia	NO / YES
Allergies	NO / YES	Kidney disease	NO / YES	Seizure disorder	NO / YES
Atrial Fibrillation	NO / YES	HPV	NO / YES	Sleep disorder	NO / YES
Mold	NO / YES	High blood pressure	NO / YES	Stroke or heart attack	NO / YES
Cancer	NO / YES	IBS	NO / YES	Traumatic brain injury	NO / YES

Other:____ _______________________________

Surgical history
____
____

Have you ever or do you currently smoke? Y/N Do you drink alcohol? Y/N Do you use THC or CBD? Y/N

Describe your current symptoms____
____

____

What medications and supplements are you taking?
____

____

What are your biggest limitations/challenges?
____

____

What have you tried for this condition in the past - including procedures, surgeries, medications, supplements, etc?
____

____

What treatments do you feel are currently helping you?
____

____

If you had a magic wand, what top three wishes would you make happen or change?

1.

2.

3.

Where would you like to see yourself in 1 year and 5 years?____

____

I have completed this form to the best of my ability and acknowledge withholding information can impact my treatment plan. I understand my insurance will not be billed for any therapies and I am solely responsible for payment. I understand therapies offered are considered experimental by the FDA and no guarantee of cure or results can be made.

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Patient Signature **Date**