



**MAUI
REGENERATIVE
MEDICINE**

2310 Umi Place Haiku Hawaii 96708

Office: 808-575-2328

www.mauiregenerativemedicine.com

Patient History Information

Name _____ Date _____

Address _____ State/Zipcode _____

Phone Home _____ Cell _____ SSN# _____

Age _____ Date of Birth _____ Sex M F

Occupation _____ Employer _____

Marital Status: S M W D No. of Children: _____ Spouse Name _____

Emergency Contact Name and Phone _____

Email _____

How did you find out about our office? _____

How do you prefer we contact you: _____

What is the reason for this visit? _____

Is this condition due to: Auto accident Work Injury Other accident Illness Other

Are symptoms: Improving Getting worse About the same Intermittent

Date symptoms appeared: _____ Have you ever had these symptoms before? Yes No

Have you seen any of the following doctors for this? MD Naturopathic Dr

Chiropractor Acupuncturist Other: _____

Therapy Received: _____ Dates treated: _____

Diagnosis: _____

Reason for termination of treatment: _____

Medications Prescribed: _____

Doctors Name: _____

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature: _____ Date _____

Please apply check to boxes below: C =currently P =previously N= never

GENERAL SYMPTOMS

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEVER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHILLS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NIGHT SWEATS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF SLEEP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	in extremities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing

MUSCLE & JOINTS

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twitching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bachache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Tailbone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in btwn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curvature

SKIN/ALLERGIES

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brusing Easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis

Have you had any of the following:

<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Polio
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps

HABITS

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee
RESPIRATORY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
GASTRO-INTESTINAL			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching/Gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver toruble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble

CARDIO-VASCULAR

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prev. Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes

EYE-EAR-NOSE-THROAT

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble

GENITO-URINARY

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Freq. urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate trouble

WOMEN ONLY

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or Backaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant at this time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap

<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Mental Disorder
<input type="checkbox"/>	Lumbago
<input type="checkbox"/>	Eczema

Family History/List Member:

Diabetes	_____
Heart	_____
Kidney	_____
Cancer	_____

NAME (Please Print): _____

DATE: _____

**USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

KEY:

S=STIFFNESS

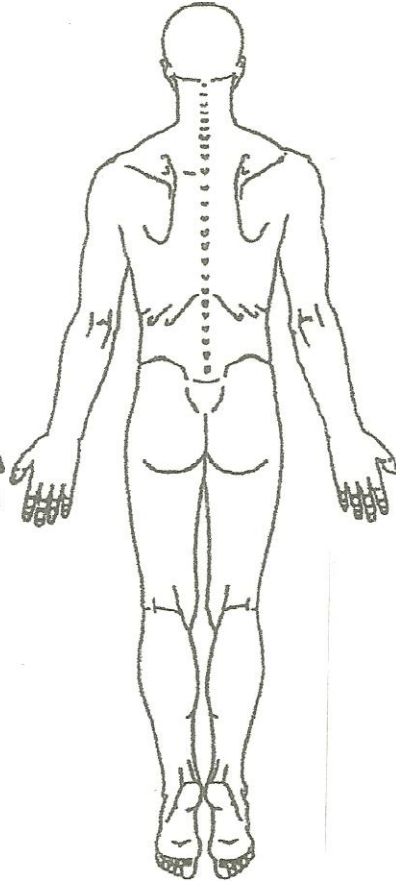
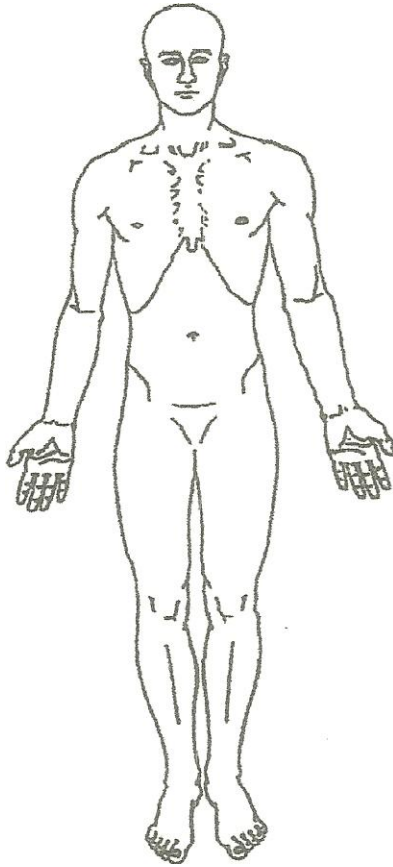
P=SHARP PAIN

B=BURNING

T=TINGLING

N=NUMBNESS

D=DULL PAIN



RIGHT



LEFT

IMPORTANT

TO THE PATIENT: Please list below the five or more main complaints you have in the order of importance. Also the length of time you have had this complaint.

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____
4. _____ How Long? _____
5. _____ How Long? _____

List other Doctors seen for this condition, their diagnosis and treatment _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

Is the condition interfering with your: Work Sleep Daily Routine Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

List Surgical operations and years: _____

Any recent injuries, falls, or accidents? _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers "Pop" Pills Tranquilizers Birth Control Pills
 Others _____

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Have you been in an auto accident: Past Year Past Five Years Over Five Years Never

Describe: _____

In case of emergency, please provide two names and phone numbers of either nearest relatives or friends _____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY			
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
DO YOU:						
Take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
DATE OF LAST:	Less than 6 mos.	6-18 mos.	Over 18 mos.	Never		
Spinal examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Physical examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chest X-ray:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spinal X-ray:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dental X-ray:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Urine Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Please indicate if your condition is a result of: Illness On-the-Job Injury Auto Accident Home Injury Other

Please check the type of care desired so that we may be guided by your wishes when possible:

Temporary Relief Control of Immediate Pain Total Health Care

I prefer the doctor select the type of care he feels is best for me.

"I understand and agree that the above information is correct as stated."

Today's Date _____ Patient's Signature _____

Regenerative Injection Therapy (RIT) Instructions Prolotherapy, PRP, and Stem Cell

Regenerative injection therapy offers tendons, ligaments, and cartilage the opportunity to repair and regenerate themselves. RIT is a non-surgical alternative recommended when loss of ligament integrity has caused the adjoining structures to be unstable. We advise that you read about RIT on our website www.mauiregenerativemedicine.com.

Below are important facts and Instructions about your RIT procedure. By signing below you indicate that you have read and understand the following information.

Pre- Treatment:

1. Do not eat a fatty meal before your treatment, but make sure you have something in your stomach.
2. Do not take any opiate pain medications 10 days before treatment.
3. If this is your first RIT treatment we ask that you bring a driver.

Post- Treatment

1. After injection you may have increased or worsening pain for a few days. This will subside. This is a normal response due to the nature of treatment.
2. You may have soreness at the injection site. This will subside.
3. For pain, you may take tylenol, AR Encap, Inflamyr, Phytoprofen, or as directed by Dr. Davison. **DO NOT** take any NSAIDs ie Advil, Ibuprofen, Aspirin, Alleve, Naproxen
3. Do not apply ice packs to treated area.
4. Do not submerge yourself in the ocean or a hot tub for 36 hours to prevent infection and more inflammation.
5. Rest the area treated. For the first 1-3 days after treatment walking and gentle range of motion is encouraged. When you feel ready and unsore, engage in general range of motion exercises-- increase *as tolerated*. If it hurts-- stop the activity.

Neck: Stationary bike or elliptical, Walking, Swimming, Integrated Qi Gong

Shoulder: Elliptical, Integrated Qi Gong

Back: Stationary bike or elliptical, Walking, Swimming, Integrated Qi Gong

Hips: Stationary bike or elliptical, Walking, Swimming, Integrated Qi Gong

Knees: Stationary bike or elliptical, Walking, Swimming, Integrated Qi Gong

Elbow, wrist, ankle: Integrated Qi Gong

It is HIGHLY RECOMMENDED not to perform any extreme sports, heavy lifting, or weight bearing activity for at least 3 weeks or as instructed by Dr. Davison.

6. The most effective regenerative exercises to promote the healing of your tendons, ligaments, and cartilage can be practiced with Dr. Davison's Integrated Qi Gong Movement System. DVDs are available in the office and on the shop page of our website.