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
HEADACHE			
FEVER			
CHILLS			
NIGHT SWEATS			
DIZZINESS			
CONVULSIONS			
LOSS OF SLEEP			
FATIGUE			
NERVOUSNESS			
Loss of Weight			
Numbness in extremeties			
Wheezing			

MUSCLE & JOINTS	C	P	N
Weakness			
Twitching			
Stiff Neck			
Bachache			
Swollen joints			
Tremors			
Painful Tailbone			
Foot trouble			
Hernia			
Pain in btwn Shoulders			
Spinal Curvature			

SKIN/ALLERGIES	C	P	N
Skin eruptions			
Itching			
Brusing Easily			
Dryness			
Boils			
Sensitive skin			
Hives			
Eczema			
Psoriasis			

HABITS	C	P	N
Smoking			
Alcohol			
Coffee			

RESPIRATORY	C	P	N
Chronic Cough			
Spitting Blood			
Spitting Phlegm			
Chest Pain			
Difficult breathing			

GASTRO-INTESTINAL	C	P	N
Poor Appetite			
Poor Digestion			
Excessive Hunger			
Belching/Gas			
Nausea			
Vomiting			
Vomiting blood			
Pain over stomach			
Constipation			
Diarrhea			
Colon trouble			
Hemorrhoid			
Liver toruble			
Jaundice			
Gall bladder trouble			

CARDIO-VASCULAR	C	P	N
Rapid heart			
Slow heart			
High Blood pressure			
Low Blood pressure			
Pace Maker			
Pain over heart			
Prev. Heart trouble			
Swelling ankles			
Poor circulation			
Varicose veins			
Strokes			

EYE-EAR-NOSE-THROAT	C	P	N
Poor vision			
Crossed eyes			
Pain in eyes			
Deafness			
Earache			
Ear Noises			
Ear Discharge			
Nasal Obstruction			
Nose Bleeds			
Sore throat			
Hoarseness			
Hay Fever			
Asthma			
Frequent colds			
Enlarged thyroid			
Tonsillitis			
Sinus trouble			

GENITO-URINARY	C	P	N
Freq. urination			
Painful urination			
Blood in urine			
Kidney Infection			
Bedwetting			
Incontinence			
Prostrate trouble			

WOMEN ONLY	C	P	N
Painful periods			
Excessive flow			
Irregular cycles			
Hot Flashes			
Cramps or Backaches			
Miscarriage			
Vaginal Discharge			
Pregnant at this time			
Abnormal Pap			

Have you had any of the following:

Appendicitis	Chicken Pox	Arthritis
Pneumonia	Diabetes	Epilepsy
Rheumatic Fever	Cancer	Mental Disorder
Polio	Heart Disease	Lumbago
Tuberculosis	Goiter	Eczema
Whooping Cough	Influenza	
Anemia	Pleurisy	
Measles	Alcoholism	
Mumps	Venereal Disease	

Family History/List Member:

Diabetes

Heart

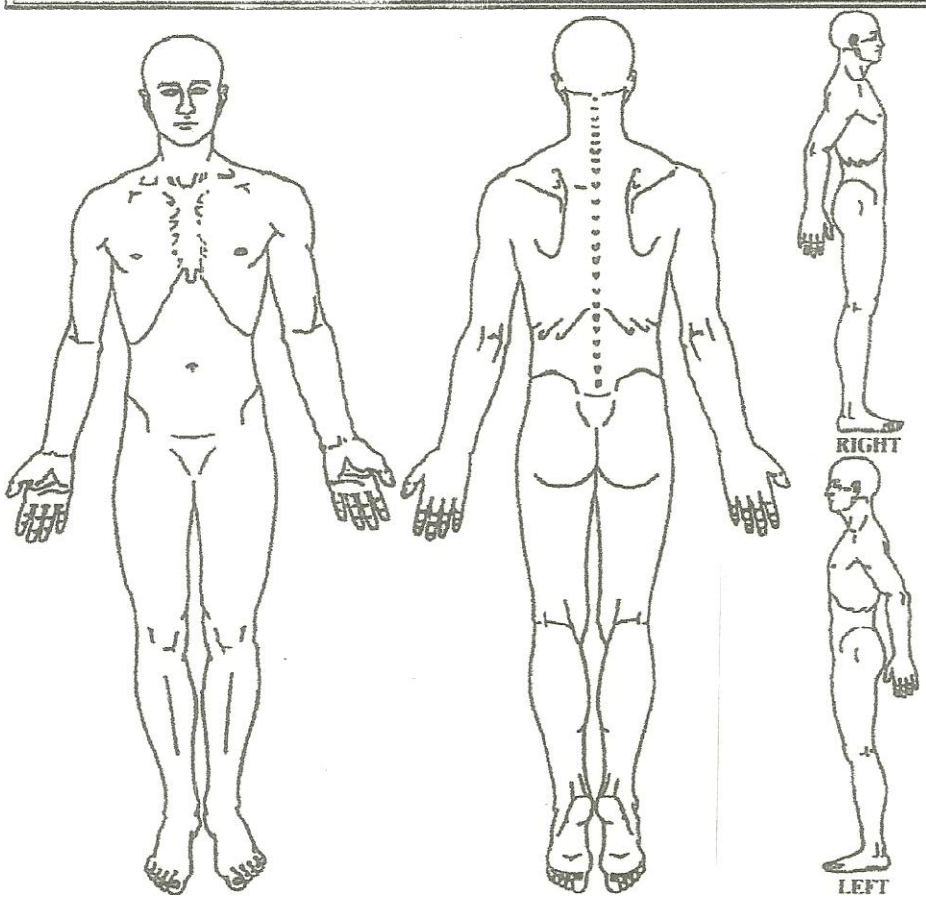
Kidney

Cancer

NAME (Please Print):_____ DATE:_____

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

KEY:	S=STIFFNESS	B=BURNING	N=NUMBNESS
	P=SHARP PAIN	T=TINGLING	D-DULL PAIN



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 ☐ "Pep" 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?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	
DO YOU:			
Take vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 mos.	6-18 mos.	Over 18 mos.	Never
Spinal examination:	☐	☐	☐	☐
Physical examination:	☐	☐	☐	☐
Blood test:	☐	☐	☐	☐
Chest X-ray:	☐	☐	☐	☐
Spinal X-ray:	☐	☐	☐	☐
Dental X-ray:	☐	☐	☐	☐
Urine Test:	☐	☐	☐	☐

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 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.