Regenerative MedSpa of Buckhead

Last Name: _____ First Name: _____ Today's Date: _____

Birth Date: _____ Age:_____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address: _____ May we contact you via email? ( )Yes ( ) No

In case of Emergency Contact:_____ Cell Phone:_____

Relationship:_____

Primary Care Physician's Name: _____ Phone:_____

Specialist's Name: _____ Phone: _____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widowed ( ) Living with Partner ( ) Single

How did you hear about us? _____

Medical History

Any Known Drug Allergies: _____

Medications / Supplements Currently Taking: _____

_____

Surgeries? List All and When: _____

Complications with Anesthesia: ( ) NO ( ) YES, Reaction _____

Medical Illnesses:

( ) High blood pressure
( ) High cholesterol
( ) Hypertension
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary embolism
( ) Arrythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other autoimmune disease
( ) Trouble passing urine (taking Flomax or Avodart)
( ) Cancer type:_____
( ) Testicular or prostate cancer
( ) Asthma / Respiratory Issues
( ) Seizures or Seizure Disorder
( ) Depression / Anxiety
( ) Arthritis
( ) Thyroid disease
( ) Diabetes
( ) Chronic liver disease (fatty liver, cirrhosis)
( ) Fibromyalgia
( ) Psychiatric disorder

Pain Questionnaire:
(Please skip if you are not here for pain related treatment)

Describe your pain problem: _____

_____

When did the pain start? _____ Did anything cause the pain? _____

Is the pain getting: ( ) Better ( ) Worse ( ) Staying the Same Is the pain: ( ) Constant ( ) Intermittent

Is your pain associated with: ( ) Numbness ( ) Tingling, Pins & Needles ( ) Weakness ( ) Coldness
( ) Bowel Problems ( ) Bladder Problems ( ) Increased Sweating ( ) Muscle Spasms/Tightness
( ) Skin Discoloration ( ) Swelling ( ) Warmth ( ) Other _____

What treatments have you had for your pain? ( ) Physical Therapy ( ) Medication ( ) Exercise
( ) Chiropractic ( ) Psychotherapy ( ) Surgery ( ) Nerve Blocks ( ) Epidurals
( ) Cortisone Injections ( ) Trigger Point Injections ( ) Botox ( ) Ketamine Infusions
( ) Other _____

What tests have you had for your pain? ( ) X-Rays ( ) MRI ( ) CAT Scan ( ) EMG ( ) Bone Scan
( ) Discogram ( ) Myleogram ( ) Other _____

If 0 is no pain and 10 is the worst imaginable pain, what is your pain level 0-10?
Worst Pain: _____ Least Pain: _____ Usual or Average Pain: _____

What prompted you to seek IV ketamine, PRP joint injections, or medical cannabis treatment? _____

_____

Psychiatric Questionnaire:
(Please skip if you are not here for psychiatric related treatment)

Principal Psychiatric Diagnosis: _____

Current Symptoms (check once for any symptoms present, twice for major symptoms):
( ) Depressed Mood ( ) Racing Thoughts ( ) Excessive Worry ( ) Unable to Enjoy Activities
( ) Impulsivity ( ) Anxiety Attacks ( ) Sleep Pattern Disturbance ( ) Avoidance
( ) Increased Risky Behavior ( ) Loss of Concentration / Forgetfulness ( ) Loss of Interest
( ) Increased Libido ( ) Decreased Libido ( ) Hallucinations ( ) Change in Appetite
( ) Decreased Need for Sleep ( ) Increased Need for Sleep ( ) Suspiciousness
( ) Excessive Guilt ( ) Excessive Energy ( ) Fatigue ( ) Crying Spells ( ) Irritability
( ) Other _____

If you suffer from depression, how long have you been affected? _____

What other forms of treatment have you tried? _____

What are your treatment goals? _____

What prompted you to seek IV ketamine treatment? _____

Habits:

( ) I smoke cigarettes or cigars _____ per day
( ) I use marijuana _____ per week
( ) I drink alcoholic beverages _____ per week
( ) I use caffeine _____ per day
( ) I have a history of substance / drug abuse

Additional Symptoms or Concerns you'd like your provider to know:

We value your business and ask that you respect our business scheduling policies. Please notify us at least 24 hours in advance of any cancellation. All cancellations with less than 24-hour notice and no-show appointments are subject to a $75 cancellation fee.

_____ (Initial) I certify that I have completed this questionnaire to the best of my knowledge. I understand I will discuss medical information in the presence of people, staff, and the clinician. If I have medical concerns that are of a very private nature, I will request to discuss with the clinician in a private setting or will schedule an individual office visit. Additionally, I have been notified of my rights to privacy.

_____ (Initial) I understand that Regenerative MedSpa of Buckhead is a cash for service clinic, and they will not file any insurance claims on my behalf.

Print Name Signature Date