Name: _____ Date: _____

Thank you for choosing to be a patient at ReGen Revolution. As you know, we are an integrated medical office. We offer several different types of services, delivered by different types of providers. We are always striving to provide the highest level of care to our patients, with the most modern technologies and treatment options. Periodically, ReGen Revolution will be adding different services to our treatment offering, to better serve you. Please indicate below anything you would like more information on.

❑ **Physical Health**: List your chief complaint: _____

- ○ *Physical medicine* - Natural muscle & Joint injections, Nerve blocks, Diagnostic tests, Headache/ Migraine treatment
- ○ *Chiropractic*
- ○ *Rehab Therapy*

❑ **Regenerative Therapy - Tissue Transplant/ HCPT / PRP:** Homologous primary use for repair, reconstruct, replace, or supplementation. This tissue is rich with the basic components necessary for tissue regeneration including: Growth Factors / Cytokines / Collagen / Fibrinogen / Hyaluronic Acid /Messenger RNA

What are some clinical uses of the injectable product that have had success?

○ Plantar fasciitis / Tendonitis (biceps, triceps) / Rotator Cuff Tears / Osteoarthritis / ACL Tears / MCL Tears /Post-operative pain (orthopedic surgeries and spine)... and much more.

❑ **Peripheral Neuropathy/ Nerve Damage (hands/feet)**: Combination of therapies to improve balance, numbness/tingling, and muscle weakness in the affected areas.

❑ **Cosmetic Regenerative Medicine:** Look younger, naturally with this non-invasive service

Vampire Facelift
Vampire Breast Lift
Vampire Facial
PRP Hair Restoration

❑ **Sexual Health Regenerative Procedures:**

Women:
O-shot: Urinary Incontinence

Men:
P-shot : Peyronies Disease, Erectile Dysfunction

❑ **Bio-identical Hormone Replacement Theory:** All natural bio-identical hormone optimization. As a person ages, hormone levels gradually slip into non-optimal ranges. This natural decline starts after age 30 and continues throughout life. Men and women experience brain-fog, low energy, difficulty sleeping, weight gain, hair loss, decreased sex- drive, and more.

❑ **IV Treatments:**

Ozone Therapy – Anti-inflammatory, acts as a disinfectant, kills bacteria, prevents viral replication. Helps remove harmful free radicals, prevent tissue damage, and improve local circulation. Higher energy levels, heals damaged cells, protecting them from future oxidative stress.

Immune Booster – B12, B2, B3, B5, B6, Vitamin C, Zinc
Myers Cocktail – B12, Magnesium Chloride, Calcium, Vitamin C
Add-ons available – Glutathione, B-Complex, Vitamin C, Magnesium, Zinc

Thank you for keeping me informed of the new services offered at ReGen Revolution.

_____

Signature

WELCOME

Patient Information

Name: _____
Last First MI

Mailing Address: _____

City/State/Zip _____

Phone# (Cell) _____ (Work) _____ (Home) _____

Best time/place to reach you? _____

Email Address: _____

Date of Birth: _____ SS#: _____

Sex assigned at birth: ☐ Male ☐ Female Preferred Gender Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor ☐ Partnered

Occupation: _____ Employer: _____

Employer Address _____

City/State/Zip: _____ Phone: _____

Spouse's Name: _____ Spouse's Birth date: _____

Spouse's Employer: _____ Phone: _____

How did you hear about our practice? _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone# (Cell) _____ (Work) _____ (Home) _____

☐ I authorize ReGen Revolution to discuss confidential medical information with the contact listed above.

Signature : _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If so, what type? ☐ Auto ☐ Work ☐ Home ☐ Other _____

Date of Accident: _____ Day of Week: _____ Time of Accident: _____

To who have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ None

☐ Other _____

Attorney Name: _____ Phone: _____

INSURANCE INFORMATION

Name of person responsible for this account:_____

Relationship to Patient:_____ Phone#_____

Do you have health insurance? ☐ Yes ☐No Subscriber's Name:_____
Subscriber's Birth date:_____ Subscriber's SSN:_____ Relationship to Patient:_____

Name of Carrier:_____ Group#:_____ Policy#:_____

Do you have secondary/additional insurance? ☐ Yes ☐No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR CURRENT INSURANCE CARD{S)

Assignment and Release (Insured Patients)

I certify that I (and/or my dependent[s]) have insurance coverage with _____ and I authorize, request and assign my insurance company to pay directly to the physician/clinic/medical practice ReGen Revolution/Downtown's Healthcare all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

_____ _____ _____
Printed Name of Patient/Guardian Patient/Guardian Signature Date

PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐Unknown _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Electric Shocks
☐Tiredness ☐Heavy Feeling ☐Cold hands/feet Hot sensation Other

How often do you have this pain?_____ Is it constant or does it come and go? _____

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Laying Down

Do you have any difficulty with: ☐Grasping objects ☐Balance ☐Walking

PATIENT HEALTH HISTORY

Who is your primary care physician? (Doctor and/or practice): _____

What treatments have you already received for your condition: ☐Medication ☐Surgery ☐Physical Therapy

☐Chiropractic ☐Massage ☐Injections ☐Other _____

Neuropathy Specific: ☐Gabapentin ☐Neurontin ☐Lyrica ☐Cymbalta ☐Creams ☐Pain Medication ☐Other_____

Name and address of other doctor(s) who have treated you for your condition: _____

Date of Last: Physical Exam:_____ Spinal X-Ray:_____ Blood Test:_____

Spinal Exam:_____ Chest X-Ray:_____ Urine Test: _____

Dental X-Ray:_____ MRI, CT-Scan, Bone Scan:_____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness ☐ Pins/Needles in Arms ☐ Light Bothers Eyes ☐ Sudden Weight Loss ☐ Nausea
☐ Back Pain/Stiffness ☐ Pins/Needles in Legs ☐ Depression ☐ Loss of Taste ☐ Cold Feet
☐ Arm/Hand Pain ☐ Fatigue ☐ Nervousness ☐ Loss of Memory ☐ Chest Pain
☐ Leg/Knee Pain ☐ Sleeping Difficulties ☐ Tension ☐ Jaw Problems ☐ Fever
☐ Headaches ☐ Loss of Smell ☐ Cold Sweats ☐ Constipation

☐ Dizziness ☐ Allergies ☐ Stomach Problems ☐ Shortness of Breath ☐ Fainting ☐ Excessive thirst or Urination

☐ Foot Pain ☐ Poor Circulation ☐ Poor Wound Healing ☐ Hand Numbness ☐ Foot Numbness ☐ Sciatica

☐ Asthma ☐ Blurred Vision ☐ Night Pain ☐ Bowel/Bladder Changes

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Bulging Discs
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chemotherapy
☐ Chicken Pox
☐ Degenerative discs
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mononucleosis
☐ Morton's Neuroma
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker/ Defibrillator
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Other _____
☐ Scarlet Fever
☐ Spinal Stenosis
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease
☐ Whooping Cough

Please list any injuries/surgeries/ hospitalizations you have had:

	Description	*Date*
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		
Hospitalizations:		

Have you had COVID? Date: _____

Have you had the COVID Vaccines? Date: _____ Date: _____ Date: _____

Please list any allergies: _____

Are you currently under drug and/or medical care? □Yes □ No If yes, explain _____

Please list any medications you are currently taking: _____

_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals}: _____

_____

How many servings of fruits & vegetables do you consume dally? (1 serving= 1 cup of raw food}: _____

Do you exercise? ☐ No ☐Frequently ☐Daily ☐Heavy

Do your work activities mostly involve: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

Do you have any of the following habits?: ☐Smoking (packs/day) _____ ☐Coffee/Caffeine (cups/day)_____
☐Alcohol (drinks/week)_____ ☐ High Stress Level/Reason_____

Do you sleep on your: ☐Back ☐Side ☐Stomach Do you use a cervical pillow? ☐ Yes ☐No

FAMILY HEALTH HISTORY

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings}

☐ Heart Disease _____ ☐Diabetes _____ ☐Arthritis _____

☐ Cancer _____ ☐Other _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

_____ _____ _____

Printed Name of Patient/Guardian | Patient/Guardian Signature | Date

CONSENT TO CARE

A patient coming to the doctor gives their permission and authority to care for them in accordance with appropriate testing, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from; latent pathological defects, illness, or deformities, which would come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____ _____

Printed Name of Patient | Patient Signature | Date

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

Printed Name of Patient

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant.

☐ No, I am definitely not pregnant at this time.

☐ I request that x-rays films not be taken because: _____

_____

Date of last menstrual period: _____

_____ _____

Patient Signature | Date

NOTICE OF PRIVACY PRACTICES - SUMMARY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Our full Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. A copy of our detailed notice of your privacy rights is available to you upon request.

ReGen Revolution uses health information about you for treatment, to obtain payment for treatment with your authorization as required for administrative purposes, and to evaluate the quality of care that you receive (check the state laws for details).

ReGen Revolution will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

ReGen Revolution may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

ReGen Revolution may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to our Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

ReGen Revolution must maintain the privacy of Protected Health Information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions, concerns or complaints, please contact our Privacy Officer at 303-292-9992.

Printed Name of Patient	Patient Signature	Date

REGEN REVOLUTION

Bio-identical Hormone Replacement Therapy Questionnaire

Female Symptom Checklist - HRT

As a person ages, hormone levels gradually slip into non-optimal ranges. This natural decline starts after age 30 and continues throughout life, but can also affect younger people. Men and women experience brain-fog, low energy, difficulty sleeping, weight gain, hair loss, decreased sex- drive, and more. This questionnaire helps our providers determine if you may be a candidate for all natural bio-identical hormone replacement therapy to address these issues.

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? ☐Yes ☐No **Do you have daily bowel movements?** ☐Yes ☐No
Do you have gas, bloating or abdominal pain after eating? ☐Yes ☐No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐0-1 day per week (Low) ☐2-3 days per week (Average) ☐More than 3 days per week (High)

Please list any prior hormone therapy?

Bio-identical Hormone Replacement Therapy Questionnaire

REGEN REVOLUTION

Male Symptom Checklist

As a person ages, hormone levels gradually slip into non-optimal ranges. This natural decline starts after age 30 and continues throughout life, but can also affect younger people. Men and women experience brain-fog, low energy, difficulty sleeping, weight gain, hair loss, decreased sex- drive, and more. This questionnaire helps our providers determine if you may be a candidate for all natural bio-identical hormone replacement therapy to address these issues.

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2.	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4.	**Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9.	**Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13.	**Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? ☐Yes ☐No **Do you have daily bowel movements?** ☐Yes ☐No

Do you have gas, bloating or abdominal pain after eating? ☐Yes ☐No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐0-1 day per week (Low) ☐2-3 days per week (Average) ☐More than 3 days per week (High)

Please list any prior hormone therapy?_____

Recent PSA: _____ **Recent Digital Rectal Exam (Date):**_____ **Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details._____