Today's Date: _____

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Patient Profile

NAME_____AGE_____BIRTHDAY_____SEX_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (home)_____ (work)_____(cell)_____

E-MAIL_____

FOR MINORS, PLEASE NOTE PARENT'S NAME AND CONTACT INFO:
_____

OCCUPATION_____ FULL TIME PART TIME RETIRED (circle one)

EMPLOYER_____

LIVE WITH: Spouse/Partner_____Parents_____Relatives_____Friends_____Alone_____

EMERGENCY CONTACT: _____ RELATIONSHIP_____

ADDRESS: _____PHONE#_____

How did you hear about Oregon Regenerative Medicine? _____

A NOTE TO OUR PATIENTS: Preventative Medicine and holistic health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. We are asking you to provide us with part of this picture by carefully and thoroughly completing this health history form. Print all information and mark any questions you do not understand.

You must understand that naturopathic physicians offer an approach to your overall care which may differ from other methods of diagnosis and treatment such as those offered by medical doctors. Our commitment is to provide you with appropriate naturopathic care and, to the extent possible, work with other health care providers equally concerned with your well-being. Our naturopathic doctors are NOT medical doctors and will never attempt to take their place in your overall health management.

WEIGHT _____ HEIGHT _____

DO YOU EXERCISE? _____ WHAT FORMS? _____HOW OFTEN?_____

WHEN AND WHERE DID YOU LAST RECEIVE MEDICAL OR HEALTH CARE? _____

_____ FOR WHAT REASON?_____

IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS?

1) _____ 2) _____ 3)_____

PLEASE LIST ALL CURRENT MEDICATIONS:

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

ARE THERE ANY PRACTITIONERS WITH WHOM YOU WOULD LIKE US TO COORDINATE CARE?

1)_____2)_____3)_____

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Patient Questionnaire

Today's Date _____

Patient's Name _____ Birth Date _____ Sex _____

Family History

	Father	Mother	Brother				Sister				Spouse/ Partner	Children					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History

Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
☐ Scarlet Fever			Jaundice			☐ Broken Bones ☐ Cracked Bones		
Diphtheria			Epilepsy			Recurrent Dislocations		
Smallpox			Migraine Headaches			☐ Concussion ☐ Head Injury		
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious		
Pleurisy			Diabetes			☐ Food ☐ Chemical ☐ Drug Poisoning		
☐ Rheumatic Fever ☐ Heart Disease			Cancer			Explain		
☐ Arthritis ☐ Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity		
☐ Bone Disease ☐ Joint Disease			☐ High ☐ Low Blood Pressure			Chronic Fatigue Syndrome		
☐ Neuritis ☐ Neuralgia			Nervous Breakdown			Any Other Disease		
☐ Bursitis ☐ Sciatica ☐ Lumbago			☐ Hay Fever ☐ Asthma			Explain		
☐ Polio ☐ Meningitis			☐ Hives ☐ Eczema					
☐ Gonorrhea ☐ Syphilis ☐ HIV			Frequent ☐ Colds ☐ Sore Throat			Weight: Now One Yr. Ago		
Anemia			Frequent ☐ Infections ☐ Boils			Maximum When		

Allergies

Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
☐ Penicillin ☐ Sulfa Drugs			Any Other Drugs			Any Foods		
☐ Aspirin ☐ Codeine ☐ Morphine			Explain			Explain		
☐ Mycins ☐ Other Antibiotics			Iodine Or Radiologic Dye					
☐ Tetanus ☐ Antitoxin ☐ Serums			Adhesive Tape			☐ Nail Polish ☐ Other Cosmetics		

Surgery

Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes
Tonsils			☐ Ovary ☐ Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had Any Other Operations		
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness		
Uterus			☐ Blood ☐ Plasma			Explain		

X-Rays

Ever Have X-rays Of . . .	No	Yes	Date	Disease Present
Chest				
☐ Stomach ☐ Colon				
Gall Bladder				
Extremities				
Back				
Mammogram				
Sigmoidoscopy / Barium Enema				
Other				

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood In Urine		
Fainting Spells			☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarged Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting Up Blood			☐ Hemorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling Of ☐ Hands ☐ Feet ☐ Ankles			☐ Any Change In Appetite ☐ Eating Habits		
Varicose Veins			☐ Any Change In Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When		
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) ☐ Indoors ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have A Vacation (Weeks Per Year)			☐ Snuff				
Have You Ever Been Treated For Alcoholism			☐ Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now Now On Gr. Daily Have You Ever Taken: ☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

Women Only

Menstrual History . . .	No	Yes		No	Yes
Age At Onset			Are You Regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration Of Period Days			Do You Have ☐ Tension ☐ Depression Before Period		
Cycle (Start To Start) Days			Do You Have ☐ Cramps ☐ Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	**No**	**Yes**		**No**	**Yes**
Children Born Alive (How Many)			Still Born (How Many)		
Cesarean Sections (How Many)			Miscarriages (How Many)		
Prematures (How Many)			Any Complications		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Patient Conditions of Treatment and Informed Consent to Treat

This document is a binding agreement (the "Agreement") between Center for Traditional Medicine P.C. DBA Oregon Regenerative Medicine ("We" "Us" "Our") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services which may be provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

1. Consent For Treatment. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Us to provide You with health care treatment which, depending on Your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, minor surgery, gynecology, radiofrequency procedures, acupuncture, prolotherapy and/or platelet rich plasma injections, stem cell injections, Intravenous micronutrient and botanical therapy and heavy metal chelation, (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments. (Initials)_____

2. Experimental Nature of Treatment. You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods including, without limit, acupuncture, intravenous micronutrient therapy, minor surgery, prolotherapy and platelet rich plasma therapy, stem cell therapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA"), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. We have informed You that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect. (Initials) _____

3. Minor Surgery, Prolotherapy, Injection Therapy Risks, Side Effects, Complications. We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments including, without limitation, swelling, increased pain, bleeding, dizziness, numbness, scarring, scar or keloid formation, asymmetry, allergic reaction, discoloration, soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments, all of which may be permanent. Treatment may very rarely cause infection, injury to nerves, temporary or permanent alteration in sensation, the need for additional surgery or hospitalization, spinal cord injuries, pneumothorax (temporary lung collapse), paralysis, or other serious or debilitating injuries or death. (Initials)_____

4. Description of Treatments. The exact procedure, as well as the recommended sequence of Treatments, will be explained to You when we actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines, and FDA approved prescriptive medicines, chelating agents, local anesthetic (Procaine, Bupivacaine, Lidocaine), concentrated sugar water or dextrose, concentrates of Your own blood (platelet rich plasma), bone marrow stem cells, fat derived stem cells and, on occasion, other substances and local subcutaneous anesthetic infiltration (with or without epinephrine) which will be explained to You before injections. (Initials)_____

5. Medical Staff. You are aware that among those who attend You on our behalf are medical, nursing and other health care personnel employed by Us or in training, who unless requested otherwise, may participate in Your patient care. (Initials)_____

6. Information You Provide Us. You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You agree to update Us periodically should this list change. (Initials)_____

7. Assumption of Risk. You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement and, after having adequate time to ask any questions about this Agreement or the Treatments that You have, You are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. (Initials)_____

8. Alternatives. You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials)_____

9. Miscellaneous. You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case anyone of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of Oregon without regard to any choice of law principal. Any dispute between You and Us shall be adjudicated in state or federal court in Clackamas County, Oregon, and You submit to the jurisdiction of any such court. (Initials)_____

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT SHOULD YOU REQUEST ONE, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS

Patient signature_____ Legal Guardian/Proxy/Representative_____

Date_____ Date_____

Print Patient Name_____ Print Name of person signing_____

Physician Certification: I nearby certify that one of my associates or I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

*Physician Signature (Center For Traditional Medicine, P.C.)*_____*Date*_____

Revised October 2018

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Consent for Communication through Phone, Voicemail, or Email

Our patients and clients frequently request that we communicate with them by phone, voicemail, or email. Oregon Regenerative Medicine respects your right to confidential communications about your protected health information. Since voicemails and emails can be inherently insecure as a method of communication, we will only communicate with you by voicemail or email at the phone numbers or email addresses you provide to us below with your written consent. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by voicemail or email you are consenting to communication that may not be encrypted. It is also possible that voicemail messages may be intercepted by others. Therefore, when you consent to communicating with us through phone, voicemail, or email you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Oregon Regenerative Medicine will not be responsible for any privacy or security breaches that may occur through phone, voicemail, or email communications that you have consented to use when communicating with us.

By initialing here, I acknowledge that Oregon Regenerative Medicine confirms patient appointments by phone and uses the telephone for other communications that do not reveal protected health information: _____

To limit your risk of exposing your protected health information to unauthorized persons, you may choose to restrict any additional types of voicemail or email communications you have with us. Please specify below the types of communication you consent to receive by voicemail and/or email:

Other than appointment confirmations and other matters regarding non-protected health information by telephone, I do not consent to any additional voice mail or email communication by placing my initials here: _____

OR

In addition to appointment confirmations and other matters regarding non-protected health information by telephone, I consent to communications about my medical condition and advice from my healthcare providers by the following means. Initial all that you consent to:

_____ Voicemail

_____ Email

Oregon Regenerative Medicine communicates periodically with current and former patients and clients through an automated email system to inform them of upcoming events, promotion specials, or other services we may offer. We may also from time to time ask for reviews or testimonials that may help potential patients make decisions regarding their healthcare. Your response to any information or request is voluntary and your participation or nonparticipation will in no way affect your treatment with us.

Please initial next to your preference:

_____I consent to be included in Oregon Regenerative Medicine's email list and to receive email communications as described above. I understand I may request to be removed from Oregon Regenerative Medicine's email list at any time.

_____I do not consent to being included in this email list and do not wish to receive any email communication as described above.

Email address(es) through which I consent to communicate:

_____

Phone number(s) through which I consent to communicate:

Patient or Guardian Signature: _____Date:_____

Revised November 2018

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

FINANCIAL POLICIES

Please take time to read and sign this financial responsibility statement before your first visit.

PAYMENT POLICY: Payment is due at the time of service. Prepayment is required to secure a scheduled new patient appointment. We accept cash, checks, MasterCard, and Visa.

INSURANCE POLICY: We believe that you are capable of making informed health care decisions. We believe we are providing the care our patients want and need. Unfortunately, health insurance companies often do not recognize the efficacy or medical necessity for the services we provide. Over the last 40 years, we have found that some insurers have created obstacles between providers and patients that waste both patient's and doctor's time, obstructing the efficiency, productivity and quality of health care delivery. For this and other reasons, we have elected to entirely opt out of insurance billing and reimbursement.

We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement. We will not bill your health insurance plan. You are financially responsible to pay for our services regardless of any denial of payment by insurance companies, benefit payments, third party interest, or the resolution of any legal actions or lawsuits in which you are involved. Under no circumstances are we responsible if any health plan, HSA, or benefit you have denies you payment for our services for any reason.

MEDICARE, MEDICARE PART B, and Medicare Advantage: If you are a Medicare beneficiary, please understand that none of our providers are enrolled as Medicare providers, and that we will not bill Medicare, and that NO Medicare plans or supplemental plans will cover or reimburse you for the services we provide.

HEALTH SAVINGS ACCOUNTS (HSA) Rules for HSA accounts vary, and we will only provide you with a bill of services that you can use, at your discretion, to document your HSA expenditures.

INTEREST FEES: All fees are due at the time of service. In the event that funds are not paid at the time of service, after 30 days all accounts are charged a monthly finance charge of 2.0% of the unpaid balance, which is an annual percentage rate of 24% (or a minimum charge of $5.00).

MISSED/LATE CANCELLATION APPOINTMENT FEES: We require two full working days notice for rescheduling or canceling new patient appointments. This requirement must be met to enable us to refund any prepayment. The prepayment fee for a new patient appointment is $340.00.

One full working day is required to change or cancel return visits for established patients. The missed/late cancelation fee for established patients for a scheduled 1/2-hour slot is $111.00; the fee for a scheduled 15-minute slot is $70.00.

I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. There will be a $50.00 fee added to any account referred to collections. I hereby authorize the Center for Traditional Medicine, P.C. and Oregon Regenerative Medicine to release any information necessary to secure payment.

ACKNOWLEDGMENT: I have read this financial policy statement and understand its terms. I acknowledge that I have chosen to obtain the services offered at Oregon Regenerative Medicine, and have agreed to pay out of pocket for the services I receive. I have no expectation that my insurance plan will reimburse me. If I am a MEDICARE beneficiary, I attest that I have chosen to not use my Medicare benefits for the services I receive and understand that Oregon Regenerative Medicine will not bill Medicare.

Print Patient's Name_____ D.O.B._____

Responsible Party _____Relationship to Patient_____

Signature of responsible party_____ Date_____

Revised October 2018

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

Protected Health Information (PHI) is defined as any information whether oral or recorded, in any form or medium that is created or received by a healthcare provider that connects the patient's name to any treatment, financial status or health status in the past, present or future. PHI is generally used when we send and receive information to/from doctors, lawyers, pharmacies and insurance companies.

If PHI is requested by another office or by the patient, we request the patient sign a release form before any information can be shared or released. There is an understanding that we may send PHI if requested by your insurance company in order to secure payment for you. Only the minimum information necessary will be shared, as a rule.

Disclosure of PHI in the following cases do not require patient consent: If the disclosure is required by law, if the request is from the public health authority, if the request involves child abuse, neglect, domestic violence, in judicial and administrative proceedings, requests from law enforcement, requests for cadaveric organ, eye or tissue donation purposes, food and drug administration requests, in cases of communicable diseases, to avert a serious and imminent threat to health and safety, or workers compensation.

Patients have the right to receive a copy of this Notice of Privacy Practices. They have the right to access their own PHI and to request amendments and restrictions. Patients have the right to not be intimidated or threatened when making these requests. We may not require them to sign a waiver relinquishing these rights in order to receive treatment. Patient's names will not be used in any fundraiser or venture without prior authorization, except for our mailing list. Patients can be removed from this list by request.

Unless we are otherwise directed, PHI will only be released to friends and/or family if the patient is incapacitated or it is an emergency and ONLY if the doctor decides it is in the best interests of the patient. If you have family members whom you would like to authorize access to your PHI, please add their name(s) to the bottom of this form. Custodial parents have access to their children's PHI if they are minors unless another agreement has been made or the doctor believes there is a possibility of child abuse/neglect.

If a patient requests an amendment of, or access to their PHI, depending on the situation, the doctor may or may not comply. If access or amendments are denied, the patient will be provided with a statement that includes the reasons for that denial. Our office has 30 days to respond to any request for information. If the requested information is kept offsite, our office has 60 days to respond. If the patient does not agree with the doctor's decision, there is an appeals process that will be explained to the patient at that time.

Our staff are trained in privacy and security procedures. The front staff members have limited access to all active patient files and also to existing archived files dating back to 1978. (CTM routinely destroys files after 10 years of inactivity). They do not have authority to review and/or release test results, or to access any PHI without appropriate reasons. The practitioners in the office have access to their patients' PHI only, unless the on call doctor needs to access the PHI to assist the patient. If the patient sees more than one doctor at ORM, information may be shared between doctors. Both Dr. Peterson and Teresa Shelley (co-owners of CTM) have access to all existing patient records dating back to 1978. I have read the above notice.

Signature: _____Date_____ Print name: _____

Please include my name on your newsletter mailing list: Yes No (circle one)

I would like a copy of this notice: Yes No (circle one)

I authorize CTM P.C. to share my PHI with: _____ Relationship:_____

A copy of our complete Privacy Policy is available in our waiting room.

Contact: Teresa Shelley, Privacy Officer (503) 636-2734

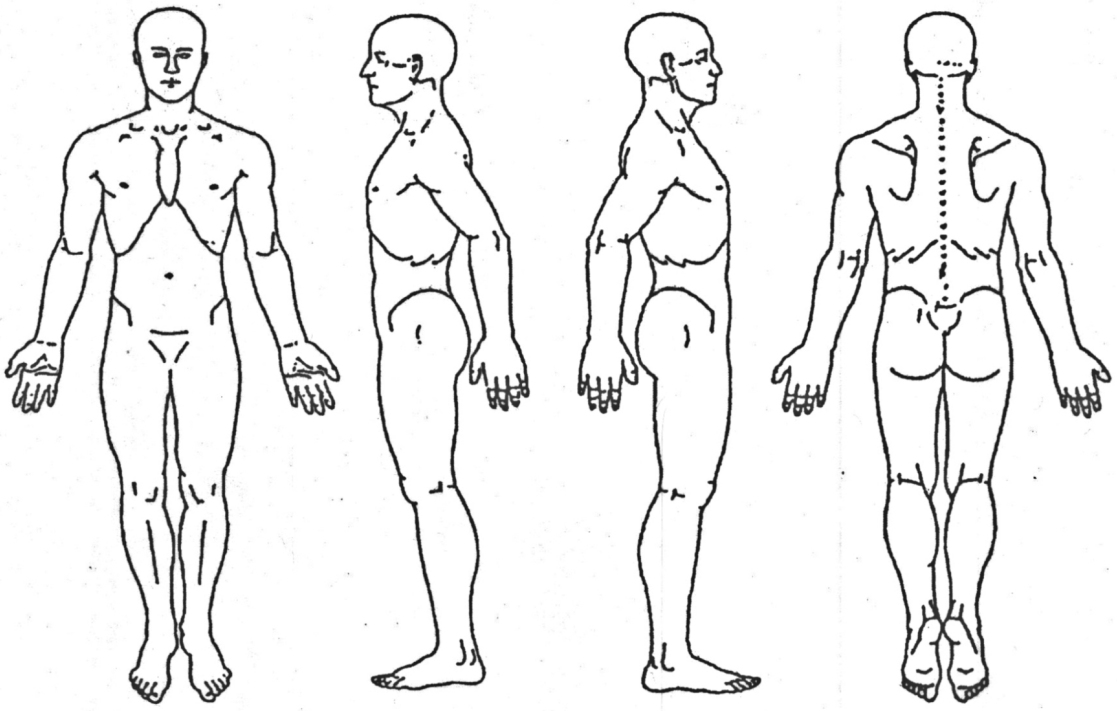
Revised August 2018

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

PAIN MANAGEMENT HISTORY

Name_____ DOB_____Age___Height___Weight____
What is your chief complaint?_____How long?_____
Other complaints?_____How long?_____
How long have you had this condition? _____
How long has it been since you felt really good?_____
What aggravates your condition? Sitting Standing Walking Exercise
Have you had evaluation or treatment of this condition with? MD____Drug therapy____
Surgery____Chiropractic____Physical Therapy___ Acupuncture___Nutrition___Other?___
Are you: Worse____Same____Some improvement____Better____Comes and goes _____
What has helped and how much has it helped?_____
_____
What hasn't helped? _____
List any surgeries or medications:_____
_____
Is there anything else you would like to say about your condition or your previous treatments?_____
_____

Please mark the drawing with: "X" = pain, "O" = stiffness or spasm, "N" = tingling



Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

SOCIAL HISTORY QUESTIONNAIRE

NAME:_____ Today's Date _____

OCCUPATION If not working skip to repetitive & recreational activities.

Job Title: _____ **Work Hours Per Day:** _____

Max Lifting Req't: Sed(<5 lbs) ☐ Light (5-20 lbs) ☐ Med (20-50lbs) ☐ Heavy (>50 lbs) ☐

Lifting Frequency: Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day) ☐

What body parts do you lift with? Knee [ ] Torso [ ] Arm [ ] Shoulder [ ] _____

Work Activity Postures:

Sitting: _____ Hrs per day Standing: _____ Hours per day Walking: _____ Hrs per day

Climbing: _____ Hrs per day Pushing: _____ Hours per day Pulling: _____ Hrs per day

Kneeling: _____ Hrs per day Reaching: _____ Hours per day Twisting: _____ Hrs per day

Repetitive Activities:

Computer: _____ Hrs per day Phone: _____ Hours per day Machinery: _____ Hrs per day

Hand Tools: _____ Hrs per day Assembly: _____ Hours per day Grasping: _____ Hrs per day

Other: _____ / _____ Hrs per day

Impact of Current Condition on Work Capacity: No Effect ☐ Painful ☐ Limits ☐ Unable ☐

Recreational Activity	**Effect of Current Condition on Performance**
_____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
_____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
_____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
_____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
_____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐

Daily Activities	**Effect of Current Condition on Performance**
Washing/Bathing	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Household Chores	
Sweeping/Vacuuming	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Dishes	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Laundry	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Yard work	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Garbage	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Other: _____	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Climbing Steps	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Lifting Groceries	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Dressing	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Sleep	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Driving	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Concentration (Reading)	No Effect ☐ Painful ☐ Limits ☐ Unable ☐
Sexual Activity	No Effect ☐ Painful ☐ Limits ☐ Unable ☐

Oregon Regenerative Medicine
Center for Traditional Medicine, P.C.

Pain Outcomes Profile

Patient Name_____ Date___/____/____

Date of Birth ____/____/____ Height_____ Weight_____

1. How long have you had pain? _____Years and ____Months

2. On a scale of 0-10, with 0 being no pain and 10 being the worst possible pain, how would you rate your pain *right now*?

   0 1 2 3 4 5 6 7 8 9 10
   no pain *worst possible pain*

3. How would you rate your pain on *average* during the *last week*?

   0 1 2 3 4 5 6 7 8 9 10
   no pain *worst possible pain*

4. Does your pain interfere with your ability to perform activities of daily living such as: dressing yourself, cooking, climbing stairs?

   0 1 2 3 4 5 6 7 8 9 10
   no pain *worst possible pain*

5. How would you rate your physical activity?

   0 1 2 3 4 5 6 7 8 9 10
   significant limitation in basic activities *can perform vigorous activities without limitation*

6. How much do you worry about re-injuring or making your pain worse if you are more active?

   0 1 2 3 4 5 6 7 8 9 10
   not at all *all the time*

7. Do you use prescription pain meds? Y/N

   Which ones? _____ Dose ____/day ____/week #months?_____

   _____ Dose ____/day ____/week #months?_____

8. Do you use over-the-counter pain meds? Y/N

   Which ones? _____ Dose ____/day ____/week #months?_____

   _____ Dose ____/day ____/week #months?_____

9. Do you use natural or nutritional pain meds? Y/N

   Which ones? _____ Dose ____/day ____/week #months?_____

   _____ Dose ____/day ____/week #months?_____

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WOMAC OSTEOARTHRITIS INDEX

Patient's Name _____Today's Date_____

1. The following questions concern the amount of pain you are currently experiencing in your knees. For each situation, please enter the amount of pain you have experienced in the past 48 hours.

		None	mild	moderate	severe	extreme
A. Walking on a flat surface	A.	☐	☐	☐	☐	☐
B. Going up or down stairs	B.	☐	☐	☐	☐	☐
C. At night while in bed	C.	☐	☐	☐	☐	☐
D. Sitting or lying	D.	☐	☐	☐	☐	☐
E. Standing upright	E.	☐	☐	☐	☐	☐

2. Please describe the level of pain you have experienced in the past 48 hours for each one of your knees.

		None	mild	moderate	severe	extreme
A. Right knee	A.	☐	☐	☐	☐	☐
B. Left knee	B.	☐	☐	☐	☐	☐

3. How severe is your stiffness after first awakening in the morning?

None	mild	moderate	severe	extreme
☐	☐	☐	☐	☐

4. How severe is your stiffness after sitting, lying, or resting later in the day?

None	mild	moderate	severe	extreme
☐	☐	☐	☐	☐

5. The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 48 hours, in your knees.

What degree of difficulty do you have with:

		None	mild	moderate	severe	extreme
A. Descending (going down) stairs	A.	☐	☐	☐	☐	☐
B. Ascending (going up) stairs	B.	☐	☐	☐	☐	☐
C. Rising from sitting	C.	☐	☐	☐	☐	☐
D. Standing	D.	☐	☐	☐	☐	☐
E. Bending to floor	E.	☐	☐	☐	☐	☐
F. Walking on a flat surface	F.	☐	☐	☐	☐	☐
G. Getting in/out of car	G.	☐	☐	☐	☐	☐
H. Going shopping	H.	☐	☐	☐	☐	☐
I. Putting on socks/stockings	I.	☐	☐	☐	☐	☐
J. Rising from bed	J.	☐	☐	☐	☐	☐
K. Taking off socks/stockings	K.	☐	☐	☐	☐	☐
L. Lying in bed	L.	☐	☐	☐	☐	☐
M. Getting in/out of bath	M.	☐	☐	☐	☐	☐
N. Sitting	N.	☐	☐	☐	☐	☐
O. Getting on/off toile	O.	☐	☐	☐	☐	☐
P. Heavy domestic duties (mowing the lawn, lifting heavy grocery bags)	P.	☐	☐	☐	☐	☐
Q. Light domestic duties (such as tidying a room, dusting, cooking)	Q.	☐	☐	☐	☐	☐

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Hip Pain Questionnaire

Patient Name_____ Date_____/_____/_____

1. Have you had pain recently (within the last 3 months) on the affected hip? (Please circle responses)

Right Side: Yes / No

If yes:

Location:	Buttock	Groin	Thigh	Side	Lower Back	Knee
Severity:	None	Mild	Moderate		Severe	Excruciating
Frequency:	Never	Rarely	Occasionally		Frequently	Always

Left Side: Yes / No

If yes:

Location:	Buttock	Groin	Thigh	Side	Lower Back	Knee
Severity:	None	Mild	Moderate		Severe	Excruciating
Frequency:	Never	Rarely	Occasionally		Frequently	Always

2. Do you have difficulty with:

Putting on socks/shoes?	None	Slight	Moderate	Great	Unable
Personal care (toilet, bathing, etc.)	None	Slight	Moderate	Great	Unable
Household activities (cleaning, etc.)	None	Slight	Moderate	Great	Unable
Getting in and out of a car?	None	Slight	Moderate	Great	Unable

3. How much assistance do you need with going up and down stairs?

None Cane/Crutch/Banister 2 crutches Walker/someone's assistance Unable

4. How far can you walk (before your pain limits you)?

Unlimited 10+ blocks 4-10 blocks 1-3 blocks Housebound

5. Please select your favorite recreational activities and how often you would participate in them:

a.	Walking (>1 mile)	Never	Rarely	Occasionally	Frequently	Always
b.	Running	Never	Rarely	Occasionally	Frequently	Always
c.	Swimming	Never	Rarely	Occasionally	Frequently	Always
d.	Gym Workout	Never	Rarely	Occasionally	Frequently	Always
e.	Tennis	Never	Rarely	Occasionally	Frequently	Always
f.	Golf	Never	Rarely	Occasionally	Frequently	Always
g.	Gardening	Never	Rarely	Occasionally	Frequently	Always
h.	Other: _____	Never	Rarely	Occasionally	Frequently	Always

6. How often does your affected hip influence or prohibit the performance of these activities?

Never Rarely Occasionally Frequently Always

7. How often does your affected hip influence your social activities? (recreation, traveling)

Never Rarely Occasionally Frequently Always

8. How often does your hip pain influence your sense of well-being? (emotionally, mentally)

Never Rarely Occasionally Frequently Always

9. Please rate your degree of satisfaction with your ability to use your hip:

0 1 2 3 4 5 6 7 8 9 10

Unsatisfied *Fully Satisfied*