Regenerative Wellness Consultation

PERSONAL INFORMATION – To be filled out by patient

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email _____

Spouse 's Name_____ Phone Number_____

Your Occupation_____ Retired? Yes No

GENERAL SYMPTOMS Pease check ALL that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Arthritis in Hand
- ☐ Arthritis in Feet
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor wound healing
- ☐ Excessive thirst or urination

DENTAL HISTORY Please check ALL that apply

- ☐ Loose Teeth
- ☐ Root Canals
- ☐ Crooked Teeth
- ☐ Gum Recession
- ☐ Ailing Implants
- ☐ TMJ
- ☐ Bad Breath
- ☐ Amalgams- Silver/Mercury
- ☐ Extractions
- ☐ Missing Teeth

PRESENT HEALTH CONDITION

In order of importance, list the issues you are interested in correcting.

1._____

2._____

3._____

List approximately how long you have noticed these problems.

1._____

2._____

3._____

Is there a certain time of day any of these problems are better or worse?

_____

_____

Circle the things you have used for these problems:

RX Medications: _____

Aleve *Tylenol* *Ibuprofen* *Motrin*

Massage Therapy *Chiropractic* *Physical Therapy*

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Is your balance/walking ability affected?
If yes, please describe:

What do you think is causing your problem?

List the doctors you have seen for these problems, treatment you received:

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse

List anything that makes your condition better

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Electric Shocks
☐ Fatigue	☐ Heavy Feeling	☐ Cold Hands/ Feet	☐ Reduced Mobility

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes daily?

Do you drink? ☐ Yes ☐ No If yes, how many drinks daily?

Do you exercise regularly? ☐ Yes ☐ No If yes, how much exercise daily?

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Please give name and office phone number of your primary care physician.

Name_____Phone_____

When were you last seen there? _____

May we send them updates on your treatment/condition? ☐ Yes ☐ No

List ALL allergies/sensitivities to medication, food, and other items here: Reaction:

_____ _____

_____ _____

_____ _____

List the prescription drugs you are currently taking (or you may attach a list):

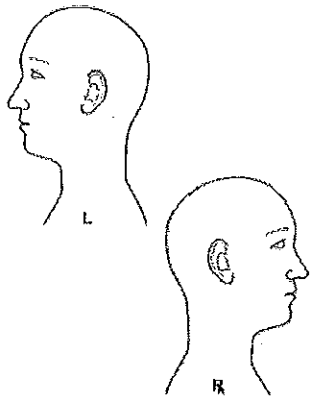
Name	Dose (mg or IU)	Times Daily

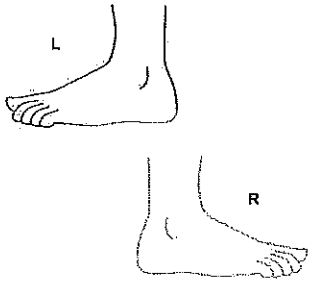
List all nutritional supplements (vitamins, herbs, homeopathies, etc.) :

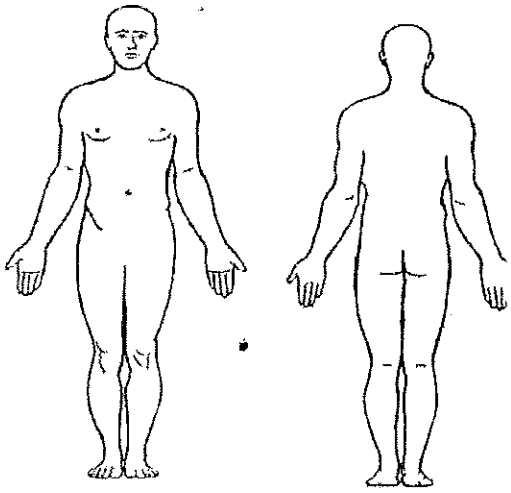
Name	Dose (mg or IU)	Times Daily

Please mark the area & type of pain on the drawings using the codes listed below.

N - Numbness T - Tingling S - Soreness P - Pain A - Ache ST - Stiffness







This is a confidential record of your medical history. The doctor reserves the right to discuss this information with medical professionals Copies of this record can only be released with your specific authorization.

Name_____Signature_____

(Patient)

Informed Consent for Stem Cell Therapy

HUMAN UMBILICAL CORD STEM CELLS

The undersigned patient/guardian does hereby acknowledge and confirm that they have received a consultation regarding stem cell therapy and that consultation shall not serve in any capacity as a replacement for their primary care physician/provider. The consultation is to discuss, without guarantee, the possibility that the infusion/injection therapy could provide some therapeutic benefit to the patient. It is further understood that the program designed for you, including any procedures or modalities (intravenous therapies, hyperbaric oxygen therapy, etc.) are not to be construed as treatments or remedies to diagnose, treat, cure, or prevent any disease or injury.

_____ is not offering Stem Cell Therapy as a cure for any condition, disease or injury. No statements or implied treatments on this document have been evaluated or approved by the FDA.

The FDA recently re-confirmed, there is only one registered stem cell product, and while there is enormous promise in stem cell therapies, and thousands of ongoing experimental applications trying to establish efficacy, these are not at the point where they would meet the scientific standard.

The FDA has stated:
Stem cells, like other medical products that are intended to treat, cure or prevent disease, generally require FDA approval before they can be marketed. FDA has not approved any stem cell-based products for use, other than cord blood-derived hematopoietic progenitor cells (blood forming stem cells) for certain indications.

http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194655.htm

"There is a potential safety risk when you put cells in an area where they are not performing the same biological function as they were when in their original location in the body." Cells in a different environment may multiply, form tumors, or may leave the site you put them in and migrate somewhere else.

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm286155.htm

Stem cell therapies have enormous promise, but the science in each use is still in the developmental stage. Professional judgment and expertise is needed in using stem cells for any therapeutic use, and we urge anyone embarking on the use of stem cell therapies to consult the national health databases to evaluate current information from clinical trials and the FDA websites on human tissue should also be consulted to get its current evaluation of any therapy.

It is the consultant's obligation to provide you with the information you need in order to decide whether to consent to the special procedure(s) being recommended to you.

Your signature on this document shall serve as verification that you have received that information and have given your consent to the procedure. You should therefore read this and any attached information carefully and ensure that all your concerns have been addressed by the consultant sufficiently before you give consent.

You understand if a chiropractor consulted with you regarding your neuromusculoskeletal condition, you are being referred to licensed medical professionals for stem cell therapy and the protocols will be up to their professional medical opinion.

Referral for the following procedure has been recommended:

Upon your authorization and consent, this Joint Injection and/or Intravenous Stem Cell Therapy will be performed on you by an authorized licensed healthcare practitioner. All invasive procedures carry the risk of unsuccessful results, complication, injury, or even death from both known and unforeseen causes, and no warranty or guarantee is made as to results or cure. You have the right to be informed of the nature of the procedure and it's actual or potential risks, benefits, and side effects, as well as any reasonable alternative(s) and the side effects of such alternative(s). You also have the right to give or refuse consent to any proposed procedure or therapy at any time prior to its performance.

Stem cells arrive frozen, and once received they must be injected that day. By signing below, you are acknowledging that there is no refund if you do not keep your appointment.

Therefore, as stated above, your signature on this form indicates that:

1. You have read and understand the information provided in this form and any attachment to this form.
2. The procedure has been adequately explained as set forth above, along with risks, benefits, and other information described on this form.
3. You have had the chance to ask any and all questions regarding this procedure.
4. You have received all of the information you desire concerning the procedure.
5. You authorize and consent to the performance of the procedure with complete understanding of it and its risks and benefits.

Date:_____Time:_____AM/PM

Signature_____

Patient/Parent/Conservator/Guardian

Printed Name & Relationship to Patient:

Witness:

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Post Therapy Guideline Recommendations

- **Activity modifications**
  - ✓ It is recommended that you rest for the first 24 hours. You are able to return to moderate daily activities after 24 hours.
  - ✓ If you received stem cell therapy for general wellness, there are no activity modifications and you can resume normal activity.

- **Injection site care:**
  - ✓ Your therapy site will be covered with a band-aid. Occasionally patients may experience soreness, swelling, redness, bruising or irritation at the injection site. If you experience worsening redness, swelling or fever, please contact the office.

- **Returning to sports and workouts following joint injections**:

  First 4 weeks
  - ✓ Participate in normal daily activities. No running, working out, or heavy lifting. Light stretching and range of motion exercises are encouraged. This will allow for joint repair.

  Weeks 4 – 8
  - ✓ increase activities as tolerated, i.e. deeper stretching and non-resistant exercises.
  - ✓ Avoid high impact activities or weight lifting with the joint involved in the therapy.

  Weeks 9 – 12
  - You may begin light weight training or band exercises progressing as tolerated and increase sport specific activities as tolerated.

- **Post injection Medications:**
  - ✓ If possible, continue to avoid anti-inflammatory medications and herbal supplements.
  - ✓ Take Tylenol for discomfort. Do not routinely take (NSAIDs) such as Ibuprofen (Motrin, Advil), and Naproxen (Aleve) for a total of **3 months following your procedure**. You may take them on occasion.

- **Follow up with the clinic in 3 - 4 weeks.**

- Practice cautious optimism. Results vary for each patient, and some treatments take 3-6 months to see full results. You may consider another treatment if a significant level of repair is not achieved. Data reports that regeneration occurs over 1-6 months. Give your body time to heal. It is worth the wait!

The above are only recommendations. The final determination is to be made by the licensed healthcare practitioner.

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Pre-Therapy Guideline Recommendations

- There are no food restrictions before your procedure.
- Plan a day of rest on the day of your procedure.
- Inform the office of any allergies.
- Stop all alcoholic beverages (May resume 3 days after therapy).
- Report all medications, supplements, and over the counter drugs to your provider.
- Evaluate the use of medications with your primary care physician, as described below. We recommend the following:

    - ✓ Minimize herbal and prescriptive anti-inflammatories and/or steroid based therapies 3 weeks prior to your procedure.
    - ✓ Stop cholesterol medicine such as "statins". Research indicates that statin drugs may decrease the effectiveness of stem cell therapy. (May resume 2 weeks after therapy).

- **The day before your stem cell therapy**

    - ✓ Drink at least 32 oz. of water (unless you are on a fluid restriction).

- **The day of your stem cell therapy**

    - ✓ Prior to your appointment drink 32 oz. of water. After you receive therapy drink another 16 oz. of water.

The above are only recommendations and do not prohibit therapy. The final determination is to be made by the licensed healthcare practitioner.

REVISED November 17, 2018