Hello, and welcome to the world of regenerative orthopedic medicine! If you have found your way to this form, you are interested in what regenerative orthopedic medicine can do to help with your specific musculoskeletal condition(s). If you would like to establish yourself as a patient with our practice, please fill out the following form and submit it to us prior to your appointment.

As part of our commitment to provide you with extraordinary care, your new patient appointment will include an in-depth physical, a dynamic musculoskeletal ultrasound exam, and a review of your past imaging. X-ray and MRI images are both useful – they will need to be two years old or newer to provide us with the most accurate information. It is recommended that your images be copied on a compact disc; you may send them ahead of time or bring them with you on the day of your evaluation appointment.

To learn more about the procedures we offer, to view the most up to date outcome data, or to listen to patient testimonials, please visit the Regenexx website.

We look forward to providing you with the best regenerative orthopedic care that is currently available.

- Jonathan Fenton, D.O.
- Kelsey Albert, D.O.

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

New Patient Intake Form

Basic Patient Information

Name:		**Phone number:**	
Mailing Address:			
Email Address:			
Date of Birth:		**Sex**:	❑ Male ❑ Female
Ethnicity:	❑ Non-Hispanic ❑ Hispanic	**Race**:	
Marital status:	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed		
Occupation:		**Employer**:	
Education level:			
Emergency Contact:		**Phone number:**	
Primary Doctor:		**May we send them a report?**	❑ Yes ❑ No
Referring Doctor:		**May we send them a report?**	❑ Yes ❑ No
Motor vehicle or workplace injury?	❑ No ❑ Yes	**Date of injury:**	
Briefly describe how your problem(s) began:			

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

Current medications: ex. Aspirin 81mg 1x/daily (please include non-prescription medicines and supplements)	
Allergies: Please list the drug/substance name(s) with type and severity of your reaction(s)	
Do you currently use/consume?	Tobacco or Tobacco products: ❑ No ❑ Yes Marijuana: ❑ No ❑ Yes, how often: Alcohol: ❑ No ❑ Yes, how many drinks per week:
What do you do for exercise? How long? How often?	
List any past surgeries and the year performed:	

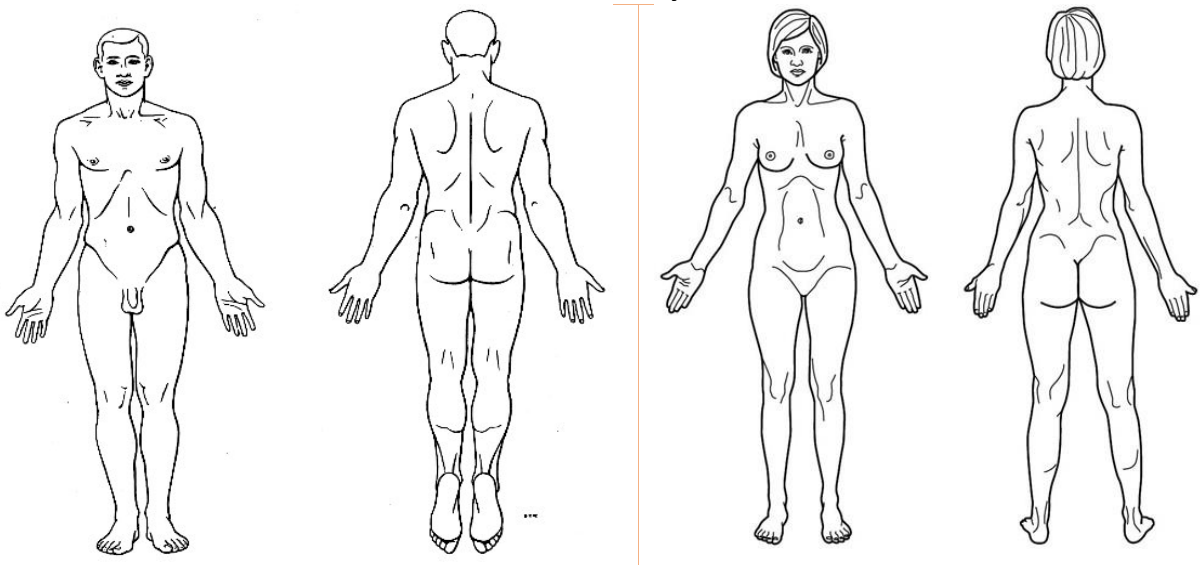
321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

VERMONT REGENERATIVE MEDICINE

Regenexx®

Location of Present Pain/Dysfunction

Please indicate where you suffer from pain or dysfunction and list from most to least severe. Be specific! ex. Inside of my right knee. Hint: use the highlighter function if filling out electronically



1:	
2:	
3:	
4:	
5:	

Severity of pain:	❑ Mild ❑ Moderate ❑ Severe
From 0 (No pain) to 10 (Agonizing):	At best __/10 At worst ___/10 Now _/10
Quality:	❑ Aching ❑ Burning ❑ Sharp ❑ Cramping ❑ Spasming ❑ Numbing ❑ Electric shock
Frequency:	❑ Intermittent ❑ Continuous ❑ Waxes and wanes
Does your pain Radiate:	❑ No ❑ Yes, where?

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

VERMONT REGENERATIVE MEDICINE

Regenexx®

What makes your pain worse?	Back and Legs: ❑ Lifting ❑ Twisting ❑ Weight bearing ❑ Prolonged sitting ❑ Prolonged standing ❑ Walking ❑Uneven terrain ❑ Other: Neck and Arms: ❑ Lifting ❑ reaching overhead ❑ reaching behind back ❑ looking up/down ❑ Other:
What makes your pain better?	❑ Nothing ❑ Rest ❑ Ice ❑ Heat ❑ Stretching ❑ Walking ❑ Sitting ❑ Standing ❑ Frequent positional changes ❑ Tylenol ❑ Ibuprofen ❑ naproxen ❑Muscle relaxant medication ❑ Pain medications ❑ Exercise ❑ Physical therapy ❑ Chiropractic ❑ Massage ❑ Other:
Treatments attempted:	❑ Nothing ❑ Ice or Heat ❑ Physical Therapy ❑ Steroid injections ❑ NSAIDs (Ibuprofen, Aleve, Naproxen) and how often? Other treatments:
Do you have weakness?	❑ No ❑ Yes, where?
Tingling, numbness, or decreased sensation?	❑ No ❑ Yes, where?
Do you limp when you walk?	No ❑ Yes ❑

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

VERMONT REGENERATIVE MEDICINE

Regenexx®

Personal Medical History

Please indicate if you suffer from any of the following conditions:

Alcoholism	☐	**Migraines**	☐
Hepatitis	☐	**History of fainting**	☐
AIDS	☐	**Lyme disease**	☐
Anemia	☐	**Other chronic infection**	Type:
Low platelet count	☐	**Gout**	☐
Other bleeding disorder	Type:	**Rheumatoid arthritis**	☐
Sleep apnea	☐	**Psoriatic arthritis**	☐
Cancer	Type:	**Reactive arthritis**	☐
Diabetes	☐	**Other autoimmune condition**	Type:
COPD	☐	**Osteoporosis**	☐
Depression	☐	**Scoliosis**	☐
Anxiety	☐	**Ankylosing spondylitis**	☐
Drug abuse	☐	**DISH**	☐
Heart attack	☐	**Low thyroid**	☐
Heart disease	☐	**Low testosterone**	☐
Kidney disease	☐	**Low estrogen**	☐
Stroke	☐	**Other endocrine condition**	Type:
Generalized joint hypermobility	☐	**Ethlors-Danlos Syndrome**	☐

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

VERMONT REGENERATIVE MEDICINE

Regenexx®

Review of Systems

Are you currently experiencing any of these symptoms?

Constitutional symptoms:	❑ Fever ❑ weight loss ❑ weight gain ❑ extreme fatigue
Eyes:	❑ Double vision ❑ blurry vision ❑ intolerance to bright light
Ears:	❑ Hearing loss ❑ tinnitus (ringing) ❑ discharge
Nose:	❑ Bleeding ❑ discharge ❑ congestion ❑ post-nasal drip
Mouth:	❑ Dental problems ❑ bleeding gums ❑ TMJ pain
Cardiovascular:	❑ Chest pain ❑ palpitations or irregular heartbeat
Respiratory:	❑ Cough ❑ wheezing ❑ shortness of breath ❑ trouble taking a deep breath
Gastrointestinal:	❑ Nausea ❑ vomiting ❑ abdominal pain ❑ constipation ❑ diarrhea ❑ blood in stools ❑ loss of appetite ❑ heartburn (GERD)
Musculoskeletal:	❑ Other pains not listed, location:
Skin:	❑ Rash ❑ itching ❑ abnormal sweating
Genitourinary:	❑ Irregular periods ❑ vaginal bleeding after menopause ❑ frequent or painful urination ❑ bloody urine ❑ impotence ❑ pain with sex
Neurological:	❑ Headache ❑ sleep complaints ❑ tingling or numbness ❑ weakness
Psychiatric:	❑ Depression ❑ anxiety ❑ suicidal thoughts ❑ little interest or pleasure in doing things
Endocrine:	❑ Excessive thirst ❑ cold or heat intolerance ❑ excessive urination or appetite ❑ hair loss ❑ very dry skin ❑ leg/feet swelling
Hematologic:	❑ Unusual bruising or bleeding ❑ enlarged lymph nodes ❑ edema

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

VERMONT
REGENERATIVE MEDICINE

Regenexx®

Family History

Please indicate any individual in your immediate family who suffers from the following:

Similar problems to yours?	❑ No	❑ Yes	Who?
Disability	❑ No	❑ Yes	Who?
Arthritis	❑ No	❑ Yes	Who?
Heart Disease	❑ No	❑ Yes	Who?
Diabetes	❑ No	❑ Yes	Who?
Cancer	❑ No	❑ Yes	Who?
Auto Immune disease	❑ No	❑ Yes	Who?
Thyroid disease	❑ No	❑ Yes	Who?
Elevated cholesterol	❑ No	❑ Yes	Who?
Hypertension	❑ No	❑ Yes	Who?
Other:	❑ No	❑ Yes	Who?

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

Financial Policy

Name: _____

You, the patient, are responsible for your medical bills. If you are covered by an insurance which Vermont Regenerative Medicine bills, we will submit the forms for you and bill you for any remaining balance. If you have an insurance that we do not bill, we will give you a form which you can submit yourself. Not all insurances cover office visits and currently no regenerative medicine treatment is covered by any insurance. If you elect to proceed with a regenerative medicine procedure, you will be required to pay the full price on the day of the procedure.

Co-pays and dispensary purchases are due at the time of service.

I have read, understood, and agree to the Financial Policy. I authorize the release of any information necessary to process my claims. I also give permission for your office to leave a message on my phone.

Signature: _____ Date: _____

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com

HIPAA Acknowledgement

Name of Patient: _____ Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Vermont Regenerative Medicine's Notice of Privacy Practices

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

321 Main St. Suite C, Winooski, VT 05404
(802) 859-0000 Fax: (802) 859-0005
VermontRegenerativeMedicine.com