Welcome to Northwest Center for Regenerative Medicine

Dr. Lewis looks forward to your new patient evaluation. Our clinic is located at 3124 S. Regal St. Spokane, WA 99223.

We ask that you please submit the following new patient paperwork prior to your appointment. If you are unable to provide your paperwork before your appointment, please contact our patient care coordinator, Margaret Starry, by phone at (509) 588 - 7340 ex. 410 to make other arrangements.

Please email to: mstarry@nwc4rm.com

Or please fax to: (509) 559 - 7514

Imaging, such as MRI or X-Ray, will be included in your chart. However, if you have not done so, please disclose the location(s) of prior imaging concerning the areas of complaint you would like to review during your evaluation with Dr. Lewis.

Thank you for the opportunity to be a part of your patient care. If you have questions regarding your appointment, please call (509) 588-7340.

Respectfully,

Northwest Center for Regenerative Medicine

General Information:

Regenexx procedures have not yet been approved by the United States Food and Drug Administration. For this reason, you are encouraged to consult with your primary care physician prior to undergoing Regenexx procedures. Our clinic also does not and cannot bill insurance for procedures, as we do not contract with insurance companies. ***Payment in full is required prior to scheduling all services.***

Questions about our clinic or Regenexx procedures? Visit our website at https://nwc4rm.com/ to learn more about our clinic and the procedures we offer. For further information on Regenexx procedures and/or a look at patient outcome data, see https://regenexx.com/.

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DEMOGRAPHIC FORM

Name: (Last)_____(First)_____(MI)_____ Female☒_____Male☒_____

Social Security No. _____ Age:_____DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone: (Home)_____ (Cell) _____

(Work) _____ Employer: _____

How did you hear about us: ☒Provider Friend/Family Google/Bing Print ad (Where?) Other (Please Specify)

Primary Care Provider's Name (First, Last): _____

Contact: (Phone)_____(Email)_____

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my physician and/or provider, may be considered necessary or advisable while a patient at ***Northwest Center for Regenerative Medicine***. I also understand that ***Northwest Center for Regenerative Medicine*** may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Patient Name: _____ Date: _____

Patient Signature: _____ Time: _____

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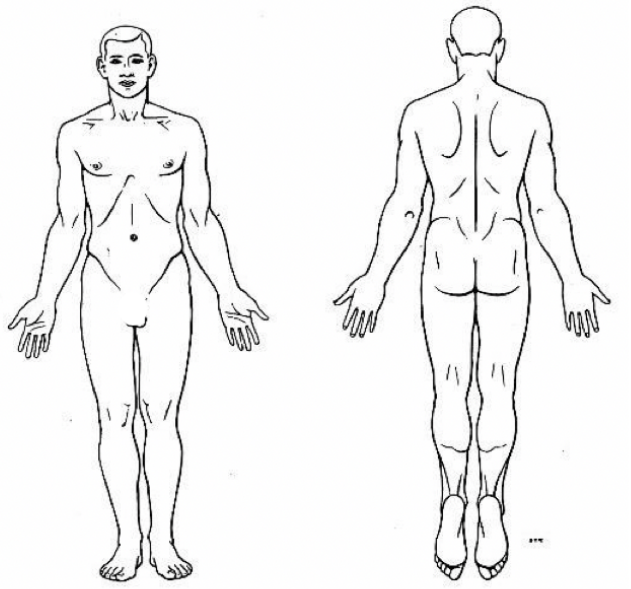
MEDICAL HISTORY FORM

Date:_____

Patient Name:_____ **Age:**_____ **Sex:** ☐ F ☐ M

CURRENTLY

The following questions are about how your illness is affecting you now. During your medical evaluation, please be prepared to indicate where your pain is on the drawing below. You may indicate it with X's or shades. Pay special attention to the directions with the arrows showing each part of the body.



List your pain and problems in order of severity (most severe first):

1._____

2._____

3._____

4._____

Please describe how your illness or pain began:_____

Since the injury or when your problem began, your symptoms are: ☐ Better ☐ Worse ☐ Unchanged

At this time are your symptoms: ☐ Better ☐ Improving ☐ Getting Worse ☐ Unchanged

Is there anything that INCREASES your pain/symptoms?	Is there anything that RELIEVES your pain/symptoms?
_____	_____

Check the box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very severe (horrible)	9-10 Unbearable (excruciating)
Your pain as it usually feels	☐	☐	☐	☐	☐	☐
Your pain as it is right now	☐	☐	☐	☐	☐	☐
Your pain at it's worst	☐	☐	☐	☐	☐	☐
Your pain when it hurts the least	☐	☐	☐	☐	☐	☐

How many days a week do you experience pain? ☐ Daily ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Intermittent

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PAST / OTHER MEDICAL HISTORY

PAST MEDICAL HISTORY *(Current medical problems such as diabetes, hypertension or high cholesterol)*	**Diagnosis**	**Treating Physician**

PREVIOUS TRAUMA *(Automobile accident, fractures, strains, any other)*	**Date**	**Injury/Accident**	**Remaining Problems**

ALLERGIES *(medications or environmental)*

MEDICATION AND SUPPLEMENTS *(please all medications you take—even if only occasionally)*	**Medication**	**Dose**	**How Often**	**When Started**	**Why?**

SURGICAL HISTORY	**Surgery**	**Date**	**Surgeon**

FAMILY HISTORY	Disability ☐Yes ☐ No	Alcoholism ☐Yes ☐ No	
	Arthritis ☐Yes ☐ No	Rheumatoid Arthritis ☐Yes ☐ No	
	Heart Disease ☐Yes ☐ No	Degenerative Disc Disease ☐Yes ☐ No	
	Diabetes ☐Yes ☐ No	Drug Abuse ☐Yes ☐ No	

SOCIAL HISTORY	Occupation? _____			
	Do you smoke?	☐Yes ☐No	If yes, how much?	_____
	Do you drink alcohol?	☐Yes ☐No	If yes, how much/often?	_____
	Do you use recreational drugs?	☐Yes ☐No	If yes, how much/often?	

ACTIVITY LEVEL	Recreational activity level? _____
	Goals for treatment?

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SYMPTOMS

The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each

	Never	Occasional	Frequent
GENERAL			
Fatigue	☐	☐	☐
Irritable	☐	☐	☐
Hot/cold	☐	☐	☐
Chills	☐	☐	☐
Sweats	☐	☐	☐
Tremors	☐	☐	☐
Weight gain	☐	☐	☐
Weight loss	☐	☐	☐
HEAD/NEUROLOGIC			
Headaches	☐	☐	☐
Head injury	☐	☐	☐
Neck injury	☐	☐	☐
Dizziness	☐	☐	
Convulsions	☐	☐	☐
Slurred speech	☐	☐	☐
Memory loss	☐	☐	☐
Concentration problems	☐	☐	☐
Weakness	☐	☐	☐
Strokes	☐	☐	☐
Carpal tunnel	☐	☐	☐
BONES/JOINTS			
Arthritis	☐	☐	☐
Bursitis	☐	☐	☐
Tendonitis	☐	☐	☐
Cramps/spasms	☐	☐	☐
Swollen joints	☐	☐	☐
Pain between shoulders	☐	☐	☐
Back pain	☐	☐	☐
Chiropractic treatment	☐	☐	
Dislocations	☐	☐	☐
Gout	☐	☐	☐
Stiffness	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain or numbness in:	☐	☐	☐
-shoulders	☐	☐	☐
-arms	☐	☐	☐
-elbows	☐	☐	☐
-wrists	☐	☐	☐
-hands	☐	☐	☐
-hips	☐	☐	☐
-legs	☐	☐	☐
-knees	☐	☐	☐
-feet	☐	☐	☐
Painful tailbone	☐	☐	☐
Poor posture	☐	☐	☐
Sciatica	☐	☐	☐
Spinal curvature	☐	☐	☐
KIDNEYS/BLADDER			
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Painful urination	☐	☐	☐
Kidney stones	☐	☐	☐
Urinary infections	☐	☐	☐
Incontinence	☐	☐	☐
FEMALES ONLY			
Painful menstruation	☐	☐	☐
Are you pregnant? ☐yes ☐no	☐	☐	☐
Pelvic pap smear	☐	☐	☐
Hot flashes	☐	☐	☐

	Never	Occasional	Frequent
EYES			
Blurry vision	☐	☐	☐
Double vision	☐	☐	☐
Eye pain	☐	☐	☐
EARS			
Ringing/buzzing	☐	☐	☐
Drainage	☐	☐	☐
Motion sickness	☐	☐	☐
Loss of hearing	☐	☐	☐
FACE/THROAT			
Sinusitis	☐	☐	☐
Frequent colds	☐	☐	☐
Problems swallowing	☐	☐	☐
Pain in chewing			
Pain in your jaw(s)	☐	☐	☐
Dentures	☐	☐	☐
LUNGS			
Tuberculosis	☐	☐	☐
Asthma	☐	☐	☐
Pneumonia	☐	☐	☐
Shortness of breath	☐	☐	☐
Chronic cough	☐	☐	☐
Wheezing	☐	☐	☐
Blood clots	☐	☐	☐
HEART			
Palpitations	☐	☐	☐
Rapid heart rate	☐	☐	☐
Chest pain	☐	☐	☐
High blood pressure	☐	☐	☐
Shortness of breath:			
-with activity	☐	☐	☐
-lying down	☐	☐	☐
Leg cramps (walking)	☐	☐	☐
Swollen feet/ankles	☐	☐	☐
CIRCULATION			
Varicose veins	☐	☐	☐
Blood clots	☐	☐	☐
Easy bleeding	☐	☐	☐
Anemia	☐	☐	☐
SKIN			
Pain	☐	☐	☐
Itching	☐	☐	☐
Dryness	☐	☐	☐
Eczema	☐	☐	☐
Rashes	☐	☐	☐
GASTROINTESTINAL			
Regurgitation	☐	☐	☐
Ulcers	☐	☐	☐
Abdominal pain	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea (frequent)	☐	☐	☐
Constipation	☐	☐	☐
Blood in stool	☐	☐	☐
Hepatitis	☐	☐	☐
Pancreatitis	☐	☐	☐

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Name:_____DOB:_____Date:_____

REVIEW OF SYSTEMS

Do you currently have or have you had in the past two weeks…

General: ☒Fever ☒Chills ☒Weight Loss ☒Weight Gain ☒Fatigue ☒Weakness

Vision: ☒Change in Vision ☒Pain With Light ☒Cataracts ☒Glaucoma ☒Recent Injury ☒Vision Loss ☒Eye Pain ☒Infections

Cardiovascular: ☒Chest pain ☒Heart murmur ☒Extremity(s) cool ☒History of heart attack ☒Ulcers on legs ☒Palpitations ☒Extremity(s) discolored ☒Leg pain walking ☒Swelling of Legs ☒High Blood Pressure ☒Thrombophlebitis

Gastrointestinal: ☒Abdominal Pain ☒Heartburn ☒Rectal Bleeding ☒Blood in Stools ☒Hepatitis ☒Excessive Hunger or Thirst ☒Hemorrhoids ☒Laxative Use ☒Swallowing Problems ☒Constipation ☒Nausea ☒Vomiting ☒Diarrhea ☒Liver Disease ☒Decreased Appetite ☒Gallbladder Disease ☒Vomiting Blood

Musculoskeletal: ☒Arthritis ☒Back Problems ☒Muscle Cramps ☒Restricted Motion ☒Joint Pain ☒Muscle Stiffness ☒Deformities ☒Weakness ☒Gout ☒Joint Stiffness ☒Paralysis

Psychiatric: ☒Depression ☒Anxiety ☒Disturbing Thoughts ☒Memory Loss ☒Psychiatric Disorders ☒Behavioral Change ☒Excessive Stress ☒Mood Changes ☒Disorientation ☒Hallucinations

Neurologic: ☒Loss of Consciousness ☒Dizziness ☒Headaches ☒Paralysis ☒Tingling ☒Numbness ☒Blackouts ☒Fainting ☒Memory Loss ☒Speech Disorders ☒Tremors ☒Burning ☒Head Injury ☒Strokes ☒Unsteady Gait

Endocrine: ☒Weakness ☒Cold Intolerance ☒Goiter ☒Weight Gain ☒Excessive Urination ☒Heat Intolerance ☒Sweats ☒Weight Loss ☒Fatigue ☒Increased Thirst ☒Thyroid Trouble

Hematologic/Lymph: Anemia ☒Swollen Glands ☒Bleeding Easily ☒Lumps ☒Blood Clots

Ears, Nose, Throat, (Allergic/Immunologic): ☒Runny Nose ☒Recurrent Infections ☒Stuffy Nose ☒Frequent Colds ☒Discharge ☒Sinus Infection ☒Nose Bleeds ☒Hearing Aid ☒Ringing in Ears ☒Tonsils Enlarged ☒Lumps ☒Tenderness ☒Asthma ☒Bronchitis ☒Shortness of Breath ☒Cough ☒Coughing Blood ☒Positive TB Test ☒Wheezing

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THIS NOTICE MUST BE PROVIDED TO YOU UNDER WASHINGTON STATE LAW. This healthcare practitioner performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider prior to undergoing stem cell therapy.

Cancellation Policies

Two business days notice is required for cancellations or rescheduling of all clinic appointments. $285.00 will be charged for cancellations or rescheduling of an evaluation given less than two business days notice. There will be a $1000.00 fee assessed to your account or retained from your original payment for procedure cancellations or rescheduling with less than two business days notice. *Please note: A 3.00% transaction fee will be deducted from all credit card refunds due to processing fees.*

If you are unable to proceed with a platelet procedure after your blood has been drawn and processed, there will be a $1500.00 fee assessed to your account or retained from your original payment due to lab costs.

If you are unable to proceed with an SD stem cell procedure after your bone marrow has been aspirated and processed, there will be a $3000.00 fee assessed to your account or retained from your original payment due to lab costs.

Patient Name: _____ Date: _____

Patient Signature: _____ Time: _____

Regenexx® at Northwest Center For Regenerative Medicine

PRE PROCEDURE INSTRUCTIONS

Arrival Time

Please arrive 15 minutes prior to your scheduled appointment unless otherwise instructed before your procedure.

General Instructions

Medications:
You will need to stop taking any NSAIDS (e.g. ibuprofen, advil, aleve, toreador, naproxen, diclofenac, and/or meloxicam), as well as blood thinners (e.g. coumadin, warfarin) for a minimum of seven days prior to your procedure. Please speak with your prescribing physician and/or our nurse for safety reasons when ceasing a medication before scheduling your procedure.

Clothing:
Wear comfortable clothing that will accommodate a dressing (if applicable).

Food and Fluids:
Blood Draw If your blood is being drawn for a platelet procedure, do not eat solids for eight hours prior to your blood draw (including chewing gum, candy, and/or mints). Clear liquids are acceptable (e.g. plain water, clear broth, clear sodas, Gatorade, and/or tea or coffee without milk or cream).

Common Injections Do not eat two hours prior to your scheduled procedure (including no chewing gum, candy, and/or mints). Do not drink two hours prior to procedure.

Bone Marrow Aspiration If you are having a bone marrow aspiration for SD stem cell procedures do not eat solids after midnight on the evening preceding your aspiration (including chewing gum, candy, and/or mints). Clear liquids are acceptable (e.g. plain water, clear broth, clear sodas, Gatorade, and/or tea or coffee without milk or cream).

Your Ride Post-Procedure and Care at Home

If you elect to have IV sedation, you must be accompanied by an adult (18 years or older) at the time of your check in. Your driver must remain at our office for the entire procedure. Failure to do so could result in your procedure being cancelled or rescheduled. A responsible individual should stay with you for up to 24 hours following your procedure for your care.

Please contact our Patient Care Coordinator, Margaret Starry, at (509) 588-7340 ext. 410 with questions or concerns.