

Please fill out this form and email it to
regenmedga@gmail.com



PAIN & HEALTH PROBLEMS SURVEY



Name: _____ Date of Birth: ____ / ____ / ____

Email Address: _____ Best Day & Time to Be Reached: _____

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ # Hrs of Work Per Week: _____

CHECK OFF WHICH OF THE FOLLOWING OCCURED AT LEAST ONCE IN THE PAST 30 DAYS:

<u>Pain</u>	<u>Decreased Motion</u>	<u>Swelling</u>	<u>Other Problems</u>
<input type="checkbox"/> Knee R L	<input type="checkbox"/> Knee R L	<input type="checkbox"/> Knee R L	<input type="checkbox"/> Overweight
<input type="checkbox"/> Shoulder R L	<input type="checkbox"/> Shoulder R L	<input type="checkbox"/> Shoulder R L	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hip R L	<input type="checkbox"/> Hip R L	<input type="checkbox"/> Hip R L	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Ankle R L	<input type="checkbox"/> Ankle R L	<input type="checkbox"/> Ankle R L	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Elbow R L	<input type="checkbox"/> Elbow R L	<input type="checkbox"/> Elbow R L	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Back	<input type="checkbox"/> Back	<input type="checkbox"/> Back	<input type="checkbox"/> Balance Problems
<input type="checkbox"/> Neck	<input type="checkbox"/> Neck	<input type="checkbox"/> Neck	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Wrist R L	<input type="checkbox"/> Wrist R L	<input type="checkbox"/> Wrist R L	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Hand R L	<input type="checkbox"/> Hand R L	<input type="checkbox"/> Hand R L	_____ Other

Which health problem bothers you the most? _____

On a scale of 1-10, at it's worst, how bad does it get? (1=low, 10=high) _____

How often does it bother you? _____

How long have you had the problem? _____

What could you do before this problem you cannot do now? _____

HOW DOES THE PROBLEM AFFECT YOU?

- | | | |
|---|--|---|
| <input type="checkbox"/> Moodiness/Irritability | <input type="checkbox"/> Restricted Activity | <input type="checkbox"/> Interferes with Exercise/Hobbies |
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Burden to My Family | <input type="checkbox"/> Reduced Enjoyment of Life |

I would like to receive a consultation and evaluation to determine a natural solution to my problems.

Best day of the week to receive an evaluation: _____

Best time of the day for me to receive an evaluation: _____

We will call to confirm your appointment.