CellMed Regenerative Medicine
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Patient Profile

Please take a few minutes to fill out this questionnaire to the best of your ability and be as thorough as possible. CellMed welcomes you and your answers will be kept confidential. Thank you for your participation.

Personal Information

Name	Phone Number	Email	Gender	Date of Birth
Address	City	State	ZIP Code	

Questions about Your Current Problem

Where are you feeling pain? When did your problem first occur?

___

How did it happen? Please check (✓) one:

☐ Accident at work or home
☐ Car Accident
☐ Other ________________________
☐ Sports Injury
☐ Following Surgery
☐ Pain just began – no specific accident
☐ Osteoarthritis
*If so, have you been diagnosed?*____

What makes your pain worse?

___

What makes your pain better?

___

Treatment History

Please check (✓) all the treatments you have received for this problem:

☐ Medication: ________________
☐ Physical Therapy
☐ Occupational Therapy
☐ Injections or nerve blocks
If so, what injections and when: ____
☐ TENS
☐ Biofeedback
☐ Acupuncture
☐ Manipulation/chiropractic treatments
☐ Surgery: ___________________________________
Date of Surgery: __________________

Diagnostic History

Please check (✓) all the tests you have done for this problem in the past 6 months:

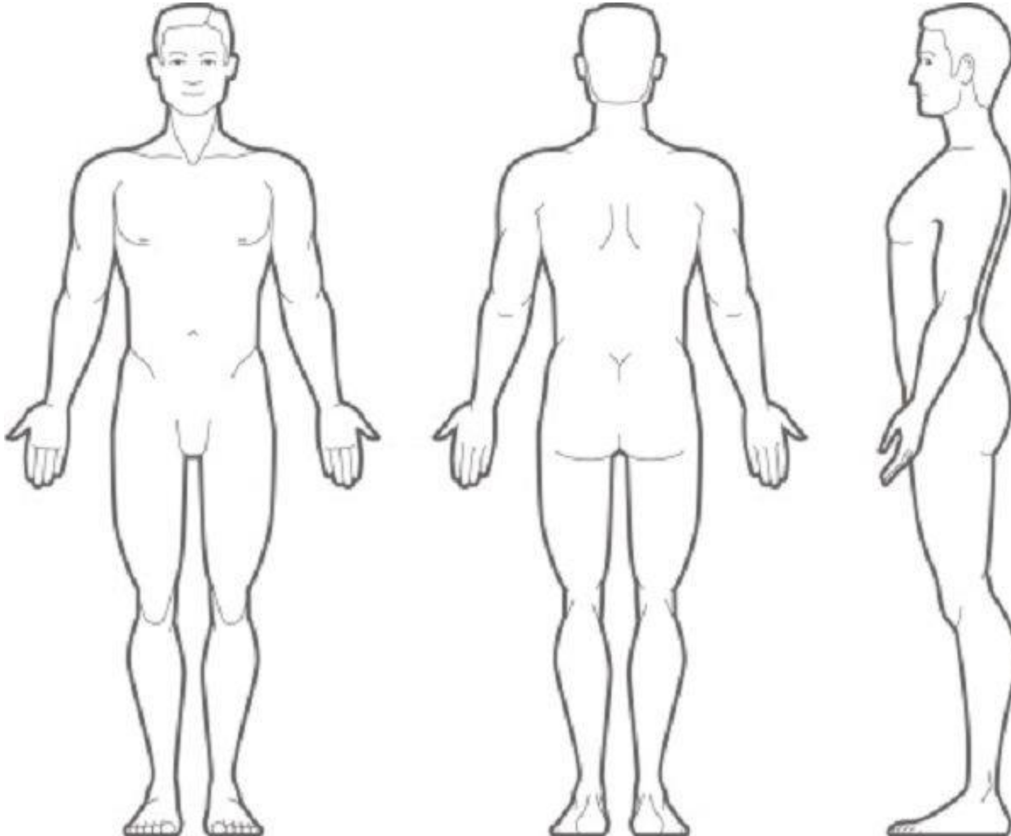
Test	When?	What Hospital/Clinic?	Findings
☐ X-Ray	_______________	______________________________	_____________________________
☐ MRI	_______________	______________________________	_____________________________
☐ CT (CAT Scan)	_______________	______________________________	_____________________________
☐ Bone Scan	_______________	______________________________	_____________________________
☐ Other	_______________	______________________________	_____________________________

Mark the areas of your body where you feel the described sensations using the following marking:

Burning: / / / /   Achiness: I I I I

Numbness: - - - -   Pins/needles: o o o o

Pain: X X X X   Stabbing: ^ ^ ^ ^



Additional Notes

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