

# 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

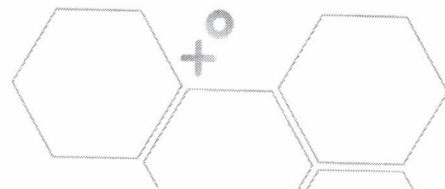
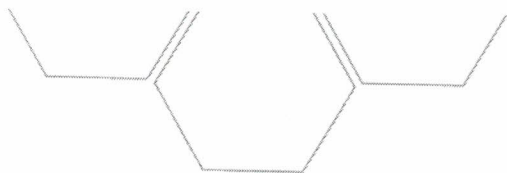
Please check ALL that apply

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

## DENTAL HISTORY

Please check ALL that apply

- |                                      |  |  |  |  |
|--------------------------------------|--|--|--|--|
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Crooked Teeth | <input type="checkbox"/> Ailing Implants | <input type="checkbox"/> Bad Breath              | <input type="checkbox"/> Extractions   |
| <input type="checkbox"/> Root Canals | <input type="checkbox"/> Gum Recession | <input type="checkbox"/> TMJ             | <input type="checkbox"/> Amalgams-Silver/Mercury | <input type="checkbox"/> 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  
*Rx Medications:* \_\_\_\_\_

*Aleve Tylenol Ibuprofen Motrin*

*Massage Therapy Chiropractic Physical Therapy*

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

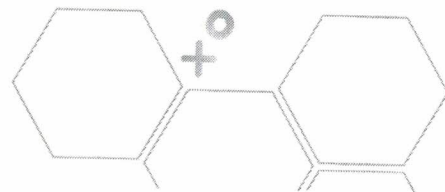
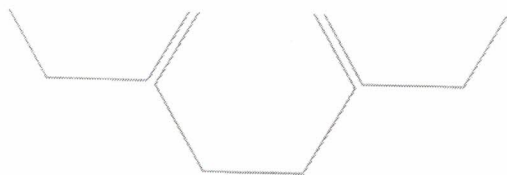
Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Aching Pain   | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Hot Sensation    | <input type="checkbox"/> Cramping         |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Tingling            | <input type="checkbox"/> Throbbing Pain   | <input type="checkbox"/> Swelling         |
| <input type="checkbox"/> Sharp Pain    | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Dead Feeling     | <input type="checkbox"/> Electric Shocks  |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Heavy Feeling       | <input type="checkbox"/> Cold Hands/ Feet | <input type="checkbox"/> Reduced Mobility |

Is this condition interfering with any of the following?

- |  |                                  |   |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep                   | <input type="checkbox"/> Work    | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing         |

## SOCIAL HISTORY

- |                            |  |  |
|----------------------------|--|--|
| Do you smoke?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many cigarettes daily? _____ |
| Do you drink?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many drinks daily? _____     |
| Do you exercise Regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> 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?

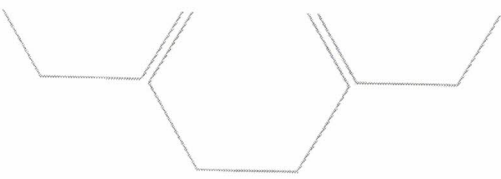
NO PAIN      1      2      3      4      5      6      7      8      9      10      WORST PAIN POSSIBLE

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

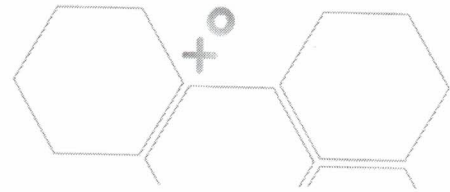
Name \_\_\_\_\_ Phone \_\_\_\_\_

When were you last seen there? \_\_\_\_\_

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



# 8 RENEWAL THERAPY



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

Reaction:

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

Name

Dose (mg or IU)

Times Daily

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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

Name

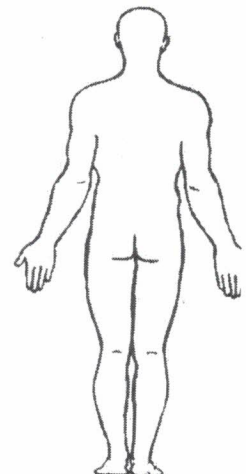
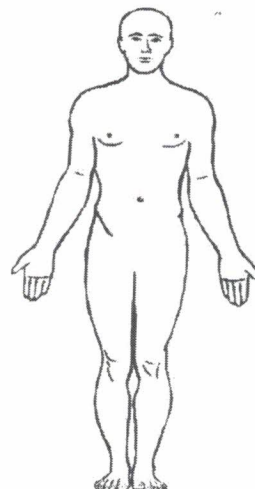
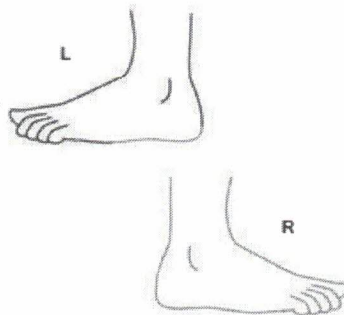
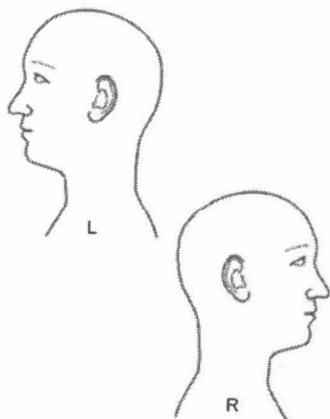
Dose (mg or IU)

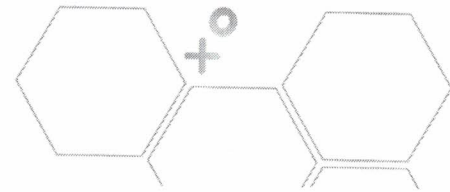
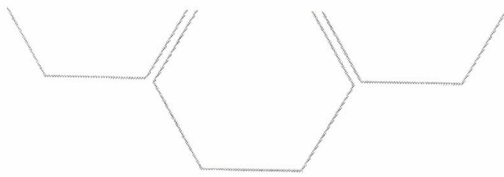
Times Daily

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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



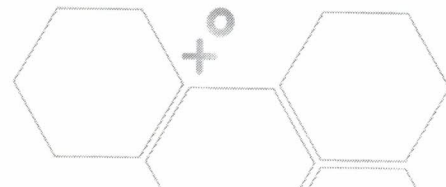
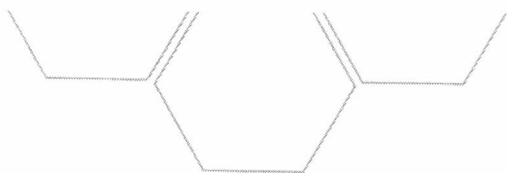


This is a confidential record of your medical history. The doctor reserves the right to discuss this information with medical professionals. Copies of this record can only be released with your specific authorization.

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.

Alternative Health Management 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:

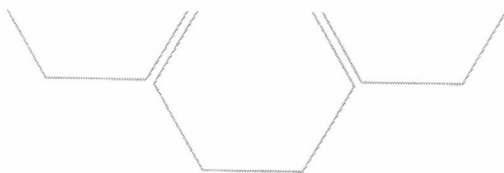
Stem cells, like other medical products that are intended to treat, cure or prevent disease, generally require FDA approval before they can be marketed. FDA has not approved any stem cell-based products for use, other than cord blood-derived hematopoietic progenitor cells (blood forming stem cells) for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

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

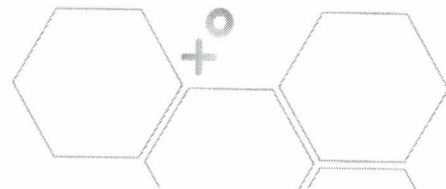
“There is a potential safety risk when you put cells in an area where they are not performing the same biological function as they were when in their original location in the body.” Cells in a different environment may multiply, form tumors, or may leave the site you put them in and migrate somewhere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



**8 RENEWAL**  
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.

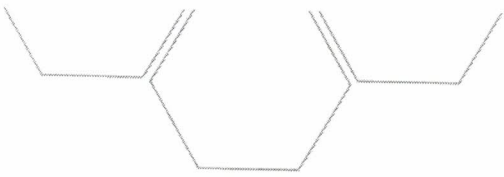
**Your signature on this document shall serve as verification that you have received that information and have given your consent to the procedure.** You should therefore read this and any attached information carefully and ensure that all your concerns have been addressed by the consultant sufficiently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

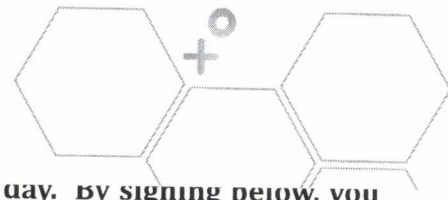
Referral for the following procedure has been recommended:

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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.



# 8 RENEWAL THERAPY



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

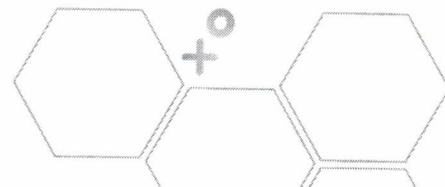
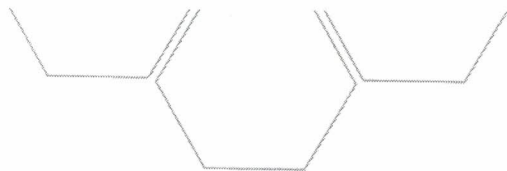
Printed Name & Relationship to Patient:

\_\_\_\_\_

Witness:

\_\_\_\_\_

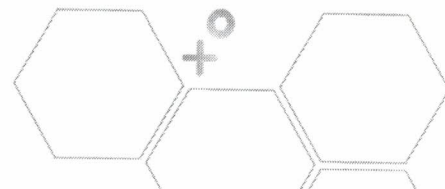
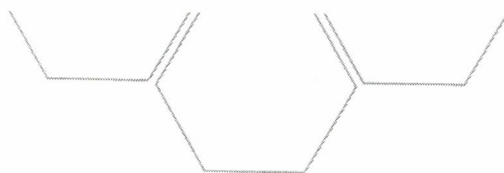




## Pre-Therapy Guideline Recommendations

- 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 before 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.*



## Post Therapy Guideline Recommendations

### RECEIVING THE SHIPMENT

- **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 lightweight 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.*