

Patient Name: _____ DOB: _____ Today's Date: _____

I would like to treat:	over the past month feeling:
1) _____	better same worse
2) _____	better same worse
3) _____	better same worse
4) _____	better same worse

Primary Care Physician: _____ Office Location: _____

Surgeries, cortisone injections, radiofrequency ablations (RFA) & **date** within past **3 years**:

1) _____	4) _____
2) _____	5) _____
3) _____	6) _____

Please circle **Allergy** to: Latex Iodine Lidocaine Procaine Codeine B12

Please circle (if **yes**) history of **Abnormal Lab Values**: Sed rate (ESR), CRP (C-Reactive Protein), Rheumatoid Factor (RF), ANA (Lupus), Lyme, Gout, Other inflammatory: _____

Diagnosed with (circle): Erlos-danlos Syndrome Rheumatoid Arthritis Ankylosing Spondylitis
Reiter's Syndrome Lyme Disease HIV Hepatitis B or C Gout

Have you taken any of the following antibiotics (circle): Cipro Levaquin Tequin

History of infection from a medical procedure: Yes No

History of vasovagal issues (fainting during procedures): Yes No

History of cancer: Yes No

Currently taking blood thinning medications (circle): Coumadin Eliquis Pradaxa Aspirin
Other: _____

Currently taking immune medications (circle): Prednisone Humira Enbrel Remicade
Other: _____

Patient signature: _____ Date: _____