CIRM
CENTER FOR
INTEGRATIVE & REGENERATIVE MEDICINE

**10190 Critzer Shop Road, Afton, Virginia 22920**
**(434) 361-1896**

# PATIENT REGISTRATION FORM

Last Name:_____

First Name:_____M.I._____

Date of Birth:_____ Sex: Male [ ] Female [ ] Social Security #:_____

Address:_____ Apt. #:____

City:_____ State:___ Country:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____

Mobile Phone:_____ Fax Number:_____

Email Address:_____

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

Spouse's Name:_____

Spouse's Work Phone: _____ Spouse's Mobile Phone:_____

Emergency Contact(s):_____

Emergency Contact Phone(s):_____

How were you referred to us?

| | |
|---|---|
| Internet | Our website |
| Another Patient (Name): | Another website: |
| Another Doctor (Name): | Blog: |
| Other: | |

## HEALTH HISTORY QUESTIONNAIRE

### FAMILY HISTORY

For each member of your family, read down the list and put a check in the boxes that apply. Put one check for each relative having a certain disease, e.g., put 3 checks in Grandparents - Stroke, if 3 of your grandparents suffered strokes. Indicate age only if deceased.

| | Father | Mother | Brothers | Sisters | Spouse | Children | Grandparents | Aunts/Uncles |
|---|---|---|---|---|---|---|---|---|
| Age (at death only) | | | | | | | | |
| Cause of Death | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Stroke | | | | | | | | |
| Seizures | | | | | | | | |
| Allergies / Asthma | | | | | | | | |
| Anemia / Blood Disease | | | | | | | | |
| Mental Illnesses / Autism | | | | | | | | |
| Genetic Disease | | | | | | | | |
| Alcoholism / Drug Abuse | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Arthritis | | | | | | | | |
| Autoimmune Disease | | | | | | | | |
| Thyroid Disease | | | | | | | | |
| Venereal Disease | | | | | | | | |
| Malaria or Tuberculosis | | | | | | | | |

### PERSONAL HISTORY

Put a check in the box next to any of the following that you now or have ever had:

| | | | | | |
|---|---|---|---|---|---|
| Q Measles | Q Chronic Sinusitis | Q Serious infection | Q Hay fever | Q Serious injury | Q other |
| Q Mumps | Q Bronchitis | Q Malaria | Q Frequent Colds | Q Alcoholism or Drug Abuse | _____ |
| Q Chicken pox | Q Pneumonia | Q Yellow jaundice | Q Neuritis or Neuralgia | Q Nervous breakdown or Psychosis | _____ |
| Q Polio | Q Pancreatitis | Q Liver disease/Hepatitis | Q Sciatica | Q Hyperactivity and/or A.D.D. | _____ |
| Q Diphtheria | Q Ulcers | Q Skin disorders | Q Low Back Pain | Q Heart trouble | _____ |
| Q Small pox | Q Diverticulosis | Q Kidney disease or Stones | Q Anemia or Blood disease | Q Hypertension/High Blood Pressure | _____ |
| Q Meningitis | Q Hernias | Q Venereal disease | Q Diabetes | Q Stroke | _____ |
| Q Scarlet fever | Q Hemorrhoids | Q Tuberculosis | Q Hormonal disorders | Q Gall Bladder disease | _____ |
| Q Rheumatic fever | Q Bone/Joint disease | Q Concussion/Head injury | Q Thyroid disease | Q Rabies | _____ |
| Q Genetic disease | Q Cancer | Q Migraines/Headaches | Q Anxiety | Q Reaction to drugs, vaccines, transfusions | _____ |
| Q Chronic Fatigue | Q Seizures/Epilepsy | Q Neurological disorders | Q Depression | To what? | |

## MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalization below. Use the reverse side if needed. (Do not include normal pregnancies)

| Year | Operation or Illness | Physician's Name | City and State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list the name and address of any other physicians who have treated you in the past year and the problem for which you were treated (Do not include visits for cold, flus or other minor acutes)

| Physician's Name | Address | Problem |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past. Please give the name and dosage of all current medicines.

| Present | Past | | Present | Past | |
|---|---|---|---|---|---|
| | | Antibiotics | | | Diabetes medicines |
| | | Pain medicine | | | Arthritis medicines |
| | | Diuretics (water pills) | | | Diet pills |
| | | Sedatives | | | Antacids or laxatives |
| | | Blood pressure medicines | | | Birth control pills |
| | | | | | Hormones |
| | | Heart medicines | | | Antimalarial drugs |
| | | Thyroid medicines | | | Antituberculosis drugs |
| | | Aspirin | | | Allergy desensitization |
| | | Vitamins & Herbs | | | Other |
| | | | | | |
| | | | | | |

## DRUG ALLERGIES

Please list any and all medicines you are allergic to, e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.

## TESTS AND IMMUNIZATIONS

Check those tests and immunizations which you have had. Enter the year when you last were given the tests or shots.

| Year | | Year | | Year | |
|---|---|---|---|---|---|
| | Chest X-Ray | | Colonoscopy/Sigmoidoscopy | | DPT |
| | Kidney X-Ray | | PAP smear | | Tetanus |
| | G.I. Series | | Nutritional Analysis | | Flu shot |
| | Colon X-Ray | | Polio series | | Pneumonia shot |
| | Electrocardiogram | | Measles, mumps, rubella | | Other |
| | TB test | | HIV vaccine | | |
| | CT or MRI scan | | Ultrasound | | |

## HEALTH FACTORS

Please check those items below that apply.

| Yes | No | Do you drink or use? | | Yes | No | |
|---|---|---|---|---|---|---|
| | | Coffee? | __ cups/day | | | Do you use an electric blanket? |
| | | Tea? | __ cups/day | | | Do you have silver-mercury amalgams in your mouth? |
| | | Sodas? | __ cans/day | | | Do you exercise regularly? |
| | | Beer? | __ cans/day | | | How much? |
| | | Wine? | __ glasses/day | | | Do you meditate regularly? |
| | | Other alcohol? | __ glasses/day | | | Do you use “recreational” drugs, e.g. cocaine, LSD, marijuana, etc.? |
| | | Cigarettes? | __ packs/day | | | Have you any known environmental sensitivities or past or present toxic chemical exposure? |
| | | Cigars? | __ cigars/day | | | Please describe: |
| | | Pipe? | __ bowls/day | | | |
| | | Chew tobacco? | | | | |
| | | Snuff? | | | | |

**Please describe your emotional nature and personality characteristics, especially the major issues in your life:**

# HEALTH QUESTIONNAIRE

If you have recently been bothered with these problems check **YES**.

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ♀ | ♀ | frequent or severe headache | ♀ | ♀ | recurring indigestion | ♀ | ♀ | aching muscles or joints |
| ♀ | ♀ | neck pains | ♀ | ♀ | frequent belching | ♀ | ♀ | swollen joints |
| ♀ | ♀ | neck lumps or swelling | ♀ | ♀ | nausea | ♀ | ♀ | back or shoulder pains |
| ♀ | ♀ | loss of balance | ♀ | ♀ | vomiting | ♀ | ♀ | weakness in arms or legs |
| ♀ | ♀ | dizzy spells | ♀ | ♀ | pain in abdomen | ♀ | ♀ | painful feet |
| ♀ | ♀ | blackouts/fainting | ♀ | ♀ | bloated abdomen | ♀ | ♀ | trembling |
| ♀ | ♀ | wear glasses | ♀ | ♀ | constipation | ♀ | ♀ | numbness |
| ♀ | ♀ | blurry vision | ♀ | ♀ | loose bowels | ♀ | ♀ | leg cramps |
| ♀ | ♀ | eyesight worsening | ♀ | ♀ | black stools | ♀ | ♀ | skin problems |
| ♀ | ♀ | see double | ♀ | ♀ | gray or whitish stools | ♀ | ♀ | scalp problems |
| ♀ | ♀ | see halos or lights | ♀ | ♀ | pain in rectum | ♀ | ♀ | itching or burning skin |
| ♀ | ♀ | eye pains or itching | ♀ | ♀ | itching rectum | ♀ | ♀ | bruise easily |
| ♀ | ♀ | watering eyes | ♀ | ♀ | blood in stools | ♀ | ♀ | nervousness or anxiety |
| ♀ | ♀ | hearing difficulties | ♀ | ♀ | frequent urination | ♀ | ♀ | nervous with strangers |
| ♀ | ♀ | earaches | ♀ | ♀ | involuntary escape of urine | ♀ | ♀ | nail biting |
| ♀ | ♀ | running ears | ♀ | ♀ | burning on urination | ♀ | ♀ | difficulty making decisions |
| ♀ | ♀ | noises in ears | ♀ | ♀ | brown, black or bloody urine | ♀ | ♀ | lack of concentration |
| ♀ | ♀ | dental problems | ♀ | ♀ | weak urine stream | ♀ | ♀ | absentminded/loss of memory |
| ♀ | ♀ | sore or bleeding gums | ♀ | ♀ | difficulty starting urine | ♀ | ♀ | lonely or depressed |
| ♀ | ♀ | sore tongue | ♀ | ♀ | constant urge to urinate | ♀ | ♀ | frequent crying |
| ♀ | ♀ | congested nose | ♀ | | **(MEN ONLY)** | ♀ | ♀ | hopeless outlook |
| ♀ | ♀ | running nose | ♀ | ♀ | burning or discharge | ♀ | ♀ | difficulty relaxing |
| ♀ | ♀ | sneezing spells | ♀ | ♀ | lumps or swelling on testicles | ♀ | ♀ | worry a lot |
| ♀ | ♀ | head colds | ♀ | ♀ | painful testicles | ♀ | ♀ | frightening dreams or thoughts |
| ♀ | ♀ | nosebleeds | ♀ | | **(WOMAN ONLY)** | ♀ | ♀ | feeling desperation |
| ♀ | ♀ | sore throat | ♀ | ♀ | a missed period | ♀ | ♀ | shy or sensitive |
| ♀ | ♀ | difficulty swallowing | ♀ | ♀ | menstrual problems | ♀ | ♀ | dislike criticism |
| ♀ | ♀ | hoarse voice | ♀ | ♀ | bleeding between periods | ♀ | ♀ | angered easily |
| ♀ | ♀ | wheezing or gasping | ♀ | ♀ | tension or pain before periods | ♀ | ♀ | annoyed by little things |
| ♀ | ♀ | frequent coughing | ♀ | ♀ | heavy bleeding | ♀ | ♀ | family problems |
| ♀ | ♀ | cough up phlegm | ♀ | ♀ | bearing down feeling | ♀ | ♀ | problems at work |
| ♀ | ♀ | cough up blood | ♀ | ♀ | vaginal discharge | ♀ | ♀ | sexual difficulties |
| ♀ | ♀ | chest colds | ♀ | ♀ | genital irritation | ♀ | ♀ | considered suicide |
| ♀ | ♀ | rapid or skipped heartbeats | ♀ | ♀ | pain on intercourse | ♀ | ♀ | sought psychiatric help |
| ♀ | ♀ | chest pains | ♀ | ♀ | swelling or lumps in breasts | ♀ | ♀ | loss or gain in weight |
| ♀ | ♀ | shortness of breath with normal activity | ♀ | ♀ | painful breasts | ♀ | ♀ | often feel warmer or colder than others |
| ♀ | ♀ | swollen feet or ankles | | | ____ # of pregnancies | ♀ | ♀ | loss of appetite |
| | | | | | ____ # of births | ♀ | ♀ | always hungry |
| | | | | | ____ miscarriages | ♀ | ♀ | armpits or groin swelling |
| | | | | | ____ premature births | ♀ | ♀ | unusual fatigue or weariness |
| | | | | | ____ cesareans | ♀ | ♀ | difficulty sleeping |
| | | | | | ____ abortions | ♀ | ♀ | fever or chills |
| | | | | | | ♀ | ♀ | motion sickness |
| | | | | | | ♀ | ♀ | excessive sweating |
| | | | | | | ♀ | ♀ | night sweats |
| | | | | | | ♀ | ♀ | hot flashes |

Comments or Special Problems:

_____

_____

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**Fax: (540) 456-6161**

# Contract for Integrative & Regenerative Medical Services

Dear Patient:

Integrative & Regenerative Medicine are distinct, specialized types of medical services apart from allopathic or conventional medical practice. Due to the unique office visit and the extraordinary amount of time and effort required by us to conduct the Integrative & Regenerative Medicine consultation and examination, the charge may not be adequately reimbursed by health insurance.

*Please note*: We are currently restricted from billing for Integrative & Regenerative Medicine services to Medicare, Medicaid, Blue Cross/Blue Shield and other health insurers. Also, Medicare and Medicaid patients may not receive reimbursement from their insurance coverage.

You will be fully responsible for the payment of all fees at the time that Integrative & Regenerative Medicine services are rendered. An invoice with the appropriate coded billing information will be provided to you for submittal to your insurance company for your reimbursement. You will be fully responsible for reimbursement of all court and legal fees for any disputes regarding our service fees.

You acknowledge the receipt of and agreement with all of our medical office's policies and fees and information within our Integrative & Regenerative Medicine Practice Information document, including those regulations regarding confirmed consultations that are cancelled and/or missed.

Please sign the following statement, which will serve as an ongoing billing contract for your current and future, Integrative & Regenerative Medicine services.

**"I understand that I am responsible for the full payment of all fees for Integrative & Regenerative Medicine consultations at the time that services are provided. Moreover, I will be responsible for all legal fees for any disputes over payment."**

Signed:_____
Patient, Parent or Guardian

Print Name:_____

Date:_____

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## Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: _____

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of the Center for Integrative & Regenerative Medicine.
I have been given the right to review the Notice of Privacy Practices prior to signing this form.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Legal Guardian (if applicable)

_____
Print Name of Patient

_____
Date

**Please kindly complete and return with the Patient Registration Form**

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**www.cirm1.org**

# POLICIES & FEES

**PLEASE NOTE**:

1) A 50% deposit is required for all new office or phone consultations. This is collected at the time that the appointment is scheduled.
2) If your new appointment is cancelled within 72 hours in advance, then the deposit for your initial consultation is refundable minus an administrative fee of $75.00. If your new appointment is cancelled after 72 hours prior to the scheduled date, then the deposit for your initial consultation is forfeited.
3) Changes to any confirmed, scheduled, follow-up office and phone consultations must be made 48 hours or more prior to the appointment. Follow-up office and phone consultations that are missed without prior notice being received by our staff will be charged an administrative fee of 75% of the appointment fee.
4) For Tuesday appointments, the cancellation notice must be received on the prior Thursday.
5) In the event of inclement weather, if you choose not to come to the office, then your confirmed, scheduled consultation will be provided via telephone. If you decline this service, you will be charged an administrative fee of 75% of the appointment fee.

**Fee Schedule**
Initial, 1 hour Integrative Medicine consultation is $495.00
2½ hour Constitutional Homeopathic Medical consultation is $1,495.00
Follow-up consultations are $195.00 (½ hour or less as needed)
An additional charge of $50.00 per ¼ hour will apply for a follow-up consultation over ½ hour
Additional fees will apply for IV Therapies, Joint Regeneration Therapy, Stem Cell Therapy, special laboratory testing, medications and/or supplements

**Billing**
Payment is due in full at the time that services are provided. We do not bill patients or insurance companies. You will be given a super-bill with all fees and pertinent coding. You will need to contact your insurance company and ask how they would like you to submit the super-bill for reimbursement directly to you.

**Medicare**
Medicare does not cover alternative and complementary medicine, including Homeopathy, Naturopathy, IV therapies, specialized testing, supplements, etc. As a result, our office cannot and does not accept Medicare insurance. Most private insurance companies tend to follow Medicare policies and will also not cover alternative, complementary medical services. You will need to read your insurance policy very carefully and be familiar with its terms and conditions.

**Phone Calls**
We realize that your phone calls are an important part of our service to you. We will make every effort to return your call as soon as possible. However, we are a very busy medical office, and if you do not hear from us, please call back.
'After-hours medical care' phone consultation services will be charged a minimum of $50.00 after the initial, free, three minutes.

**I, the undersigned, acknowledge and accept the policies and fees of CIRM:**

**Signed:**_____

**Dated:**