ARTHRITIS Health
Comprehensive Care

Rheumatology
Paul F. Howard, MD, FACP, FACR
Nisha Manek, MD, MRCP
Amanda Herron, PA-C

Naturopathy & Acupuncture
Leslie Axelrod, NMD, L.Ac.
Keith Wilkinson, NMD

Yoga Therapy
Ginnie Livingston, RN, MSN, CYT
Ellen Martinoni, CYI, RYT
Kimberly Howard, CYT
Sherry Petersen, CYT

Dear Patient,

Thank you for your interest in naturopathic care, prolotherapy, and the opportunity to work with you. Naturopathic medicine is an approach to care that provides an array of treatment options. However, more importantly, I believe naturopathic medicine offers a distinctly different way to thinking about health. Prolotherapy is one of these treatment options.

The following pages are the start of our comprehensive discussion to learn about your musculo-skeletal condition. I appreciate your time to thoughtfully answer these questions.

During the first visit we will review the history and complete a physical exam specific to your condition to determine if prolotherapy is appropriate for you. In order for me to prepare for this visit, I kindly request that this form and relevant radiology reports be mailed or faxed to Arthritis Health at least 3 days prior to your appointment. Additionally, if you have recent imaging (X-rays, MRI), please bring these to the visit.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

C. Keith Wilkinson, NMD
Naturopathic Physician

9097 East Desert Cove, Suite 100
Scottsdale, Arizona 85260

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www.arthritishealth.net

ARTHRITIS Health

New Patient Form – Prolotherapy

Date: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # Home: _____ Cell: _____ Work: _____

E-mail address: _____

Age: _____ DOB: _____ Gender: ☐ M ☐ F

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partner

Live With: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation: _____ Hours per week: _____ ☐ Retired/Not Working

Employer: _____

Additional Information

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____

Relationship to You: _____ Contact #: _____

Referral Information

How did you hear about Dr. Wilkinson? _____

Were You Referred by a Physician? ☐ Y ☐ N

If yes, could you provide us with information for the referring physician?

Referring Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

The following questions will help me understand your expectations.

1. Why did you choose to come to Arthritis Health?

2. What do you know about Prolotherapy?

3. What lifestyle habits do you currently engage in that you believe support your health?

4. What lifestyle habits do you currently engage in that you believe harm your health?

Your Current Health

Are you currently receiving medical care? Y N

If yes, where and from whom:

If no, when and where did you last receive medical care?

What was the reason?

What are your most important health problems? List in order of importance.

1.

2.

3.

4.

5.

Do you have any known contagious diseases at this time? Y N

If yes, what?

Musculo-Skeletal Conditions

Describe your M/SK history with relevant details of injuries, duration, and treatments:

Problem #1: _____

_____

_____

X-ray or MRI? _____ Results: _____

Problem #2: _____

_____

_____

X-ray or MRI? _____ Results: _____

Problem #3: _____

_____

_____

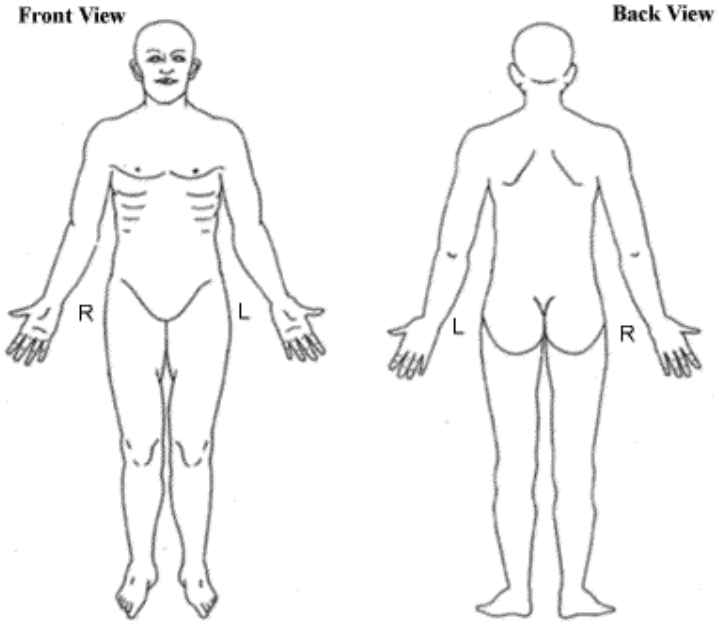
X-ray or MRI? _____ Results: _____

Do You Have any of the Following?

Headache	Y N P	Migraine	Y N P	Neck Pain	Y N P
TMJ Pain	Y N P	Hip Pain	Y N P	Sciatica	Y N P
Shoulder Pain	Y N P	Elbow Pain	Y N P	Wrist Pain	Y N P
Thumb Pain	Y N P	Finger Pain	Y N P	Muscle Spasms	Y N P
Knee Pain	Y N P	Ankle Pain	Y N P	Foot Pain	Y N P
Weakness	Y N P	Stiffness	Y N P	Numbness	Y N P
Arthritis	Y N P	Leg Cramps	Y N P	Tremors	Y N P
Upper Back Pain	Y N P	Mid Back Pain	Y N P	Low Back Pain	Y N P

note - Y = Yes you <u>have now</u> **N =** Never had **P =** Past problem (significant)

Circle any problem areas below.



Allergies

Are you hypersensitive or allergic to:
Any drugs? _____

Any foods? _____

Any substances in the environment or chemicals? _____

Current Medications / Supplements

Prescription Medications			**OTC Medications** (i.e., Ibuprofen, antacids)		
Name	*Dosage*	*Since*	*Name*	*Dosage*	*Since*

Supplements			**Other/Additional Space**		
Name	*Dosage*	*Since*	*Name*	*Dosage*	*Since*

General

Current Height: _____ / Weight:_____ Weight 1 year ago: _____

Maximum Weight: _____When: _____ Ideal Weight: _____ When: _____

Do you have sufficient energy throughout day? Y N If not, when is energy best?_____ Worst? _____

Habits/Lifestyle

Main interests and hobbies?_____

Do you exercise? Y N, If yes, what kind/how often?_____

Hours of sleep each night?	_____	Enjoy your work?	Y N
Sleep well?	Y N	Spend time outside?	Y N
Awake rested?	Y N	How many hours of TV per day?	_____
Do you need naps during day?	Y N	Do you drink coffee?	Y N P
If nap, how long/often?	_____	Do you drink sodas?	Y N
Been treated for drug dependence?	Y N P	If yes, quantity per day or week.	_____
Use alcoholic beverages?	Y N P	Do you have a sweet tooth?	Y N P
Treated for alcoholism?	Y N P	Do you use tobacco?	Y N P
		How many years and packs/day?	_____

Thank you for completing this form. See you at Arthritis Health.