VERMONT REGENERATIVE MEDICINE
JONATHAN E. FENTON, D.O., F.A.A.P.M.&R.

Board Certified in:
Physical Medicine and Rehabilitation
Neuromusculoskeletal Medicine & Osteopathic Manipulation
Orthopaedic Medicine
Musculoskeletal Ultrasound

Practice limited to:
Physical & Orthopedic Medicine
Osteopathic Diagnosis & Treatment
Image Guided Spinal & Joint Injections
Biological Regenerative Injection Treatment
Diagnostic Musculoskeletal Ultrasound

NEW ADULT PATIENT HISTORY INTAKE

To our new patients: Welcome to the practice of Jonathan E. Fenton, D.O.

To help us establish you with our practice, please provide us with your complete health history.

Today's Date:_____

PATIENT INFORMATION

Patient Name_____
Mailing Address_____Email:_____
(E-Mail needed for federally required access to your own health records)
City_____ State_____ Zip+4 code_____ + _____
Phone: Home_____Work_____Cell:_____
Preferred phone contact: __H __W __C
Date of Birth_____ Sex: M / F
Ethnicity __non-Hispanic __Hispanic (federally required that we ask!)
Race _____(federally required that we ask!)
Emergency Contact_____ Phone _____
Relationship_____
Primary Doctor_____
May we send them a report? ___Yes ___No
Referring Doctor/PA/NP/PT/other_____
May we send them a report? ___Yes ___No
Preferred Pharmacy _____

Motor Vehicle or Workplace Injury?_____
Date of Injury_____

INSURANCE INFORMATION
Insurance
Company_____
Guarantor_____

Name:_____ Date:_____

Financial Policy:
You, the patient are responsible for your medical bills. If it is an insurance which we bill we will submit the forms for you and bill you
for any unpaid balance. If it is one we do not bill we will give you a form which you can submit yourself. Not all insurances will cover
office visits. Contact your insurance carrier with coverage questions. You will be billed for missed appointments without 24 hours
notice.

Managed Care Patients Please Note
All patients are responsible for obtaining and keeping track of referrals from their primary doctors. A referral must be complete and
at our office before the actual office visit. Failure to have the referral at this office will result in the patient being responsible for
payment in full.
Co-pays and dispensary purchases are due at time of service
Patients are ultimately responsible for all payments
I authorize the release of any information necessary to process my claims. I also give my permission for your office to leave a message
on my phone.

_____
Signature
Date _____
Relationship to patient _____
(if signed by someone other than patient).

ADULT PATIENT HEALTH HISTORY

Name: _____ _____Date of Birth_____

MAIN HEALTH PROBLEMS/ REASONS FOR THIS APPOINTMENT:
(rank in terms of importance to you)
1.
_____
2.
_____

3._____
Note: we may not be able to address every problem during the course of one visit.

HISTORY OF PRESENT ILLNESS (circle or write in)
Mechanism of injury: Fall lifting reaching overhead MVA no trauma unknown other:_____
If work or motor vehicle accident, details: _____
_____
Location:_____
_____
Onset: sudden gradual_____
Severity: mild moderate severe At best __/10 At worst __/10 Now__/10
Quality: aching burning sharp cramping spasming numbing electric shock other_____
Frequency: intermittent continuous waxes and wanes_____
Radiation: yes no If yes, where to?_____
_____
What makes your pain worse: lifting, movement, twisting, rotation, weight bearing, flexion, extension, return from flexion, prolonged sitting, prolonged standing, walking, looking up/ down, other:_____
What makes your pain better: nothing. rest, ice, heat, stretching, walking, sitting, standing, frequent positional change, supine with without legs elevated, Tylenol, ibuprofen, naproxen, muscle relaxant medication, pain medication, exercises, Physical Therapy, chiropractic, massage, other: _____
_____
Treatments attempted: nothing. rest, ice, heat, stretching, walking, sitting, standing, frequent positional change, supine with without legs elevated, Tylenol, ibuprofen, naproxen, muscle relaxant medication, pain medication, exercises, bracing, crutch/cane use, Physical Therapy, chiropractic, massage, surgery, other:_____
Relief with NSAIDs (ibuprofen, naproxen, others)?:
No NSAIDs taken. none mild moderate significant

Weakness: yes no location: _____
Tingling/numbness / decreased sensation: yes no location?
_____
Bowel/bladder incontinence: yes no
Fevers: yes no
Walking disturbance/limping: none positive

Past history of injury: yes no _____
Previous relevant X-rays/MRI: yes no _____
Relevant surgery: yes no _____
Injections: yes no type:_____
History of cancer: yes no
History of osteoporosis: yes no

REVIEW OF SYSTEMS
Are you experiencing any of these symptoms?
(please circle)
Constitutional symptoms: fever, weight loss, weight gain, extreme fatigue
Head: Headaches, vertigo/dizziness, head injury
Eyes: Double vision, blurry vision, intolerance to bright light
Ears: Hearing loss, tinnitus (ringing), discharge
Nose: Bleeding, discharge, congestion, post-nasal drip
Mouth: Dental problems, bleeding gums, TMJ pain
Cardiovascular: chest pain, palpitations or irregular heartbeat
Respiratory: cough, wheezing, shortness of breath, trouble taking a deep breath
Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools, loss of appetite, heartburn (GERD)
Musculoskeletal: joint pains, muscle weakness, loss of normal range of motion
Skin: rash, itching, abnormal sweating
Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence, pain with sex
Neurological: headache, sleep complaints, tingling or numbness, weakness
Psychiatric: depression, anxiety, suicidal thoughts, little interest or pleasure in doing things
Endocrine: excessive thirst, cold or heat intolerance, excessive urination or appetite, hair loss, very dry skin, leg/feet swelling
Hematologic: unusual bruising or bleeding, enlarged lymph nodes, edema
Allergic/Immunologic: allergies, chronic infection: _____
Please list any other concerns below
_____

_____
Dietary Restrictions or type of diet followed:

_____

What do you do for exercise?

_____

How long? _____How often?_____
Do you use tobacco? **Y N**
How much tobacco do you smoke/chew per day? _____
If tobacco use in the past for how many years?_____ When did you quit?_____
How much/type of alcohol do you consume per week?_____
How much and type of caffeine do you consume per day?
(i.e., coffee, tea, chocolate, soda) _____
Other information:
_____

Marital status:
__Single ___Married ___Separated ___Divorced
Live with; ___Alone ____significant other ___roommate(s) ____children #___
Occupation: _____
Employer:_____
Education Level:_____

PERSONAL HEALTH HISTORY

Please list, in order of most recent date, any surgeries, hospitalizations, and/or accidents.

SURGERIES / Medical Issue	**Date**

Do you see any other physicians, counselors or other health practitioners? **Y N**
Who/For What?_____
_____
_____

MEDICATIONS

What prescription **and** non-prescription medicines are you taking on a regular basis? Please include vitamins, minerals, aspirin, laxatives, birth control pills, alternative medicines, etc.

Prescription Name	Dose	Frequency	Non-Prescription Name	Dose	Frequency

ALLERGIES/SENSITIVITIES

Are you sensitive to any medication or substance? **Y N Don't Know**

List type of reaction and severity (**Mi**ld **Mo**derate **S**evere)

Drug Name	Reaction	Substance Name	Reaction

SELF / FAMILY HISTORY

Check those that apply:

	SELF	Mother	Father	Siblings	Grand-Parents	Children
Alcoholism						
Alzheimer's						
Elevated Cholesterol						
Arthritis						
Asthma						
Bleeding Disorder						
Breast Cancer						
Prostate Cancer						
Colon Cancer						
Other Cancer-type??						
COPD						
Depression						
Diabetes						
Drug Abuse						
Epilepsy						
Glaucoma						
Heart Attack						
Heart Disease						
High Blood Pressure						
Irritable Bowel Syndrome						
Kidney Disease						
Lyme Disease						
Hepatitis						
Migraines						
Thyroid disease						
Other?						
Other?						
Other?						
Other?						

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Jonathan E. Fenton, D.O.

I hereby acknowledge receipt of Dr. Fenton's Notice of Privacy Practices.

Name [please print]:

_____

Signature:

_____

Date:

_____

OR
I am a parent or legal guardian of _____ [patient name].
I hereby acknowledge receipt of Dr. Fenton's Notice of Privacy Practices with respect to the patient.

Name [please print]:

_____

Relationship to Patient: Parent / Legal Guardian

Signature:

_____

Date:

_____