Beyer Stem Cell Institute
Regenerate, Rejuvenate, Restore.
17023 S. Harlem Ave Tinley Park

Dr. Edward J. Beyer

CONFIDENTIAL PATIENT INFORMATION

Date:_____ Email Address:_____

Full Name: _____

Name of Wife, Husband or Guardian: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Telephone Number: ( )_____ Cell Phone Number: ( )_____

Birth Date: _____ Male:_____ Female: _____ Marital Status: S__M__D__W__

Number of Children: _____ Currently Pregnant?_____

Occupation: _____

Employer's Name/Phone #: _____

Spouse's Occupation/Employer: _____

Name and Phone # of Emergency Contact: _____

How did you hear about our office? (Please Circle):

-Facebook Ad -Google Search -Newspaper Ad -Mailer -Referral

Appointment Reminders? ___ Voice Home ___ Voice Cell ___ Text ___ Email ___ None

Primary Complaint(s) _____

Present Symptoms(s) _____

When Symptoms Started ___/___/___/ How Symptoms Started _____

Please rate your pain from 0-10 (0= no pain; 10=extreme pain):

Body Part: _____ Pain: 0 1 2 3 4 5 6 7 8 9 10

Body Part: _____ Pain: 0 1 2 3 4 5 6 7 8 9 10

Body Part: _____ Pain: 0 1 2 3 4 5 6 7 8 9 10

What is your pain/condition holding you back from doing (ie. Sleeping, exercising, traveling, time with family, hobbies, eating healthy, etc.)? _____

_____

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List ALL medications and supplements you take. (Prescription and over-the-counter, use additional paper if needed)

Drug Name:	Dosage:	How long have you taken and for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check ALL (symptoms/pain) you may have had or do have now:

___ ADD/ADHD	___Depression	___Hepatitis	___Diabetes
___Asthma	___Fibromyalgia	___Irritable Bowel	___Ringing in ears
___Back Pain	___Kidney infection/stones	___Sinus infection	___Cancer
___Gout	___Low Blood Pressure	___Stroke	___Celiac Disease
___Headaches	___ Lyme Disease	___Thyroid Problems	___Chronic Fatigue
___Heart Attack	___Lupus	___Ulcers	___Constipation
___Heart Disease	___Rheumatoid Arthritis	___Vertigo/Dizziness	___Diarrhea
___High Blood Pressure	___Multiple Sclerosis	___Allergy	___Eczema
___High Cholesterol	___Neck Pain	___Alzheimer's	___Migraine
___High/Low Blood Sugar	___Parkinson's	___Anemia	___Emphysema
___HIV/AIDS	___Epilepsy/seizures	___Irregular Period/Cramps	

Do you consume any of the following? (Leave blank what does not apply)

Tobacco Products (packs/day) _____

Alcohol drinks/week _____

Primary Complaint: _____

When did your complaint first begin? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/symptoms you experience: _____

_____

Where exactly is the complaint area: _____

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Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

May we leave a message for you on your answering device? Yes _____ No _____

I fully understand that my signature is consent and authorization to be examined by Dr. Edward Beyer.

Patient Signature _____ Date: _____