For office use only

ImRTC™. Patient's Folder No.

Patient Evaluation Form

Click or use the TAB key to move between fields

Full Name of person filling out this form (please include Mr/Mrs/Ms or Dr)

Full name of patient (if different)

Physical Address

City/State/Zip code

Country

Postal Address (if different)

Zip/Postal Code

Telephone

Cell phone

Email

Re-type email

Skype user name (if available)

PATIENT DETAILS

Date of Birth

Occupation

Gender ☐ Male ☐ Female

Your Personal Doctor Information

Name

Telephone

Fax

Email

Emergency Contact Information: while at the clinic (caregiver, close friend or relative)

Name

Telephone

Relationship

Medical history:

Disease for which you are seeking treatment

Date of first diagnosis

Other Diagnoses	Date

What events lead up to you being diagnosed with this disease?

History of events after diagnosis

How would you describe your current condition?

Your Height

Your Weight

	Yes	No
Have you experienced sudden weight loss (above 15lbs)?	☐	☐

Do you have, or have you suffered from:

	Yes	No	If Yes, please elaborate
Allergies: food, vaccination, drugs, hayfever	☐	☐	
Heart problems	☐	☐	
High blood pressure	☐	☐	
Asthma	☐	☐	
Lung disease	☐	☐	
Epilepsy	☐	☐	
Psychiatric problems – nervousness, depression	☐	☐	
Gastrointestinal problems	☐	☐	
Liver problems	☐	☐	
Hepatitis type: A	☐	☐	
Hepatitis type: B	☐	☐	
Hepatitis type: C	☐	☐	
Renal problems	☐	☐	
Kidney infections	☐	☐	
Musculoskeletal problems	☐	☐	
Osteoporosis	☐	☐	

Osteoarthritis	☐	☐	
Rheumatoid arthritis	☐	☐	
Blood disorder	☐	☐	
Thrombosis	☐	☐	
Diabetes type 1	☐	☐	
Diabetes type 2	☐	☐	
Thyroid disorder	☐	☐	
Menopause	☐	☐	
HIV/AIDS	☐	☐	
Cancer	☐	☐	
Surgery	☐	☐	
Are you on?			
Chemotherapy	☐	☐	
Anticoagulants	☐	☐	
Antibiotics	☐	☐	
Steroids	☐	☐	

Medication

Name	Dose	Strength	Date Started	Date Stopped

Smoking or use of tobacco

Amount per day

When started

When stopped

Alcohol

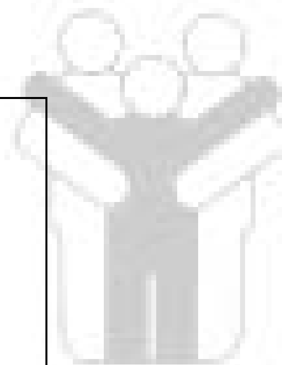
Type	Amount per day/week

Family history of disease:

Disease	Mother	Father	Grandmother	Grandfather	Brother	Sister
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

Supplementation

List all nutritional supplements – please include brand names.



Previous Stem Cell Therapy

Have you had stem cell treatment before? Yes ☐ No ☐

If *Yes*

What kind of cells did you receive?

How many cells did you receive?

Expectations

What do you expect to achieve from the treatment?

You understand that this is a treatment, and not a cure? Yes ☐ No ☐

Mobility Assessment

Please describe your ability to move by choosing a number in the list below which best describes you.

Enter the number here:

0. Asymptomatic; fully active.
1. Walks normally, but reports fatigue that interferes with athletic or other demanding activities.
2. Abnormal gait or episodic imbalance; gait disorder is noticed by family and friends; able to walk 25 feet (8 meters) in 10 seconds or less.
3. Walks independently; able to walk 25 feet in 20 seconds or less.
4. Requires unilateral support (cane or single crutch) to walk; walks 25 feet in 20 seconds or less.
5. Requires bilateral support (canes, crutches, or walker) and walks 25 feet in 25 seconds or less; *or* requires unilateral support but needs more than 20 seconds to walk 25 feet.
6. Requires bilateral support and more than 20 seconds to walk 25 feet; may use wheelchair on occasion.
7. Walking limited to several steps with bilateral support; unable to walk 25 feet; may use wheelchair for most activities.
8. Restricted to wheelchair; able to transfer self independently.
9. Restricted to wheelchair; unable to transfer self independently.

How did you hear about ImRTC™?

Internet Search	☐	What site:	
Personal referral	☐	By whom:	
Other	☐	Details:	

I understand that ImRTC is not a US FDA-approved procedure and is in no way to be construed or presented as a cure for any condition, degenerative disease or injury, and clinical benefits from this therapy cannot be guaranteed.

I accept the above ☐

Please print your Name:

Save this form to your computer & return this form as an attachment as well as any medical records or reports that you have to Patient@ImRTC.com
(this is preferred method and will expedite the process)
Or fax to 1-855-464-6782 from the United States. Outside the United States, use your international prefix. For example, if your prefix is 00, then dial 00-1-855-464-6782

Or click email icon to submit

ImRTC™ for office sse Only ***Please DO NOT write below.***