PATIENT EVALUATION FORM

For Office Use Only
ImRTC™. Patient's Case No. _____

Patient General Information

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 _____

Email Address _____ Cell Phone _____

Retype Email Address _____ Skype user name
(if available) _____

Patient Date of Birth _____ Occupation _____

Gender
Male: _____ Female: _____

Your Height & Weight
Height. _____ Weight. _____

Patient's Personal Doctor Information

Name _____ Telephone _____

Email Address _____ Fax #. _____

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

Name _____ Telephone _____

Email Address _____ Relationship _____

Patient Medical History

Disease for which you are seeking treatment _____

Date of first diagnosis _____

Other Diagnoses Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What occurrence(s) had leaded you to being diagnosed with this disease?

_____

_____

_____

History of events after diagnosis

_____

_____

_____

How would you describe your current condition?

_____

_____

_____

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

If yes? When Date _____ How much _____

How much do you weight before & now? Before _____ Now _____

Do you have, or have you suffered from:	Yes	No	If Yes, please elaborate
Allergies: food, vaccination, drugs, hay fever	___	___	_____
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	___	___	_____

Do you have, or have you suffered from:	Yes	No	If Yes, please elaborate
Cancer	___	___	_____
Any Surgery	___	___	_____

Are you on?	Yes	No	If Yes, please elaborate
Chemotherapy	___	___	_____
Anticoagulants	___	___	_____
Antibiotics	___	___	_____
Steroids	___	___	_____

Medication

Name	Dose	Strength	Start Date	End Date

Smoking or use of tobacco

Amount per day	When started	If stopped When

Alcohol

Wine	Type _____	Amount per day/week _____
Beer	Type _____	Amount per day/week _____
Liquor	Type _____	Amount per day/week _____
Other	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 (Treatments)

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?	_____
Physician (Doctor)	____	Provide Name	_____
Other	____	Give Details	_____

I understand that ImRTC ™ Stem Cell Treatments and/or Therapy 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 **Yes _____ No _____**

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, please use your international prefix. For example, if your prefix is 00, then dial 00-1-855-464-6782