

Survey for Acellular Recruitment Therapy

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Please choose **TWO** areas of severe pain that you would like to treat with umbilical recruitment therapy. Please fill out the form completely as your insurance will utilize this information to see if you qualify.

1. What is your Chief Complaint? \_\_\_\_\_ L / R / Bilateral
2. How long have you been suffering from this Problem? 3 mths 6 mths 9 mths 12 mths Other \_\_\_\_\_
3. What other areas do you currently have pain in?

<ul style="list-style-type: none"> <li>• Neck (Cervicals)</li> </ul>	<ul style="list-style-type: none"> <li>• Low Back (Lumbar)</li> </ul>
<ul style="list-style-type: none"> <li>• Shoulder: (L) or (R) or Both</li> <li>• Rotator Cuff Syndrome (Shoulder Degeneration)</li> </ul>	<ul style="list-style-type: none"> <li>• Hip: (L) or (R) or Both</li> <li>• Illiotibial Band Syndrome</li> <li>• Sciatica</li> </ul>
<ul style="list-style-type: none"> <li>• Elbow: (L) or (R) or Both</li> <li>• Tennis/ Golfers Elbow</li> </ul>	<ul style="list-style-type: none"> <li>• Knee: (L) or (R) or Both</li> <li>• Meniscus Tear/ Tendon Tear</li> </ul>
<ul style="list-style-type: none"> <li>• Finger or Thumb: (L) or (R) or Both</li> </ul>	<ul style="list-style-type: none"> <li>• Ankle: (L) or (R) or Both</li> </ul>
<ul style="list-style-type: none"> <li>• Wrist: (L) or (R) or Both</li> <li>• Carpal Tunnel Syndrome (CTS)</li> </ul>	<ul style="list-style-type: none"> <li>• Plantar Fasciitis (L) or (R) or Both</li> </ul>
<ul style="list-style-type: none"> <li>• Foot: (L) or (R) or Both</li> </ul>	Other: _____

4. Have you been recommended to have a joint replacement or spinal fusion? (Yes) or (No)  
What areas? \_\_\_\_\_
5. Have you had an X-ray or MRI done for any of these issue within the past 12 months? (Yes) or (No)  
What areas? \_\_\_\_\_
6. Approximately How long have you been suffering with these other conditions? (From #3 above)  
(< 6 months, 1-3 years, 4-5 years, 6-9 years, 10+ years)
7. What two treatments have you tried but did not work within the last 12 months?  
(General Question relative to all conditions, we will be specific when they come in).

Physical Therapy, Cortisone/Steroid injection, Chiropractic, Estim, Ultrasound, CBD Creame/Oils, NSAID's (Over-the-counters), Pain Meds, Acupuncture, Natural Supplements  
other: \_\_\_\_\_

“Remember to bring a list of any medications you are currently taking.”

8. On a scale of 1-10, for your average day, what is your level of pain or discomfort? \_\_\_\_\_
9. Insurance: Primary \_\_\_\_\_ Supplemental \_\_\_\_\_ Secondary \_\_\_\_\_