



# Stem Cells for Hope

For office use only

SCFH Patient Folder No. \_\_\_\_\_

## SCFH Patient Evaluation Form:

Click or use the TAB key to move between fields:

Today's Date:

Full Name

Date of Birth

Occupation

Gender

Male

Female

Physical Address

Country

Postal Address

Zip/Postal Code

Phone Number

Cell phone

Email

Re-enter email

Your Personal Doctor

Name

Telephone

Fax

Email

Contact in an emergency while at the clinic (caregiver, close friend or relative)

Name

Contact Phone

Medical history:

Disease for which you are seeking treatment

Date of first diagnosis

Other Medical 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 (more than 5kg/10lbs.)?

Do you have, or have you suffered from:

	Yes	No	If Yes, please elaborate
Allergies: food, vaccination, drugs, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems – nervousness, depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: A	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes type 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes type 2	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overactive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Under active	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Are you on?</u>			
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any of the following symptoms?

<b>Sensory Loss</b>	Left Side	Right Side
Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>
Thorax	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Face below eyes	<input type="checkbox"/>	<input type="checkbox"/>
Face above eyes	<input type="checkbox"/>	<input type="checkbox"/>

<b>Motor Loss</b>	Left Side	Right Side
Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>
Face below eyes	<input type="checkbox"/>	<input type="checkbox"/>
Face above eyes	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement affected	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	If Yes, please elaborate
Difficulty putting words in correct order or context:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty articulating words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty finding the correct word	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to speak	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to identify common objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Additional speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Mild	Moderate	Severe
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gait impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Incontinence</b>	Yes	No
Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	<input type="checkbox"/>

<b>Smell</b>	Yes	No
Sense of loss of smell	<input type="checkbox"/>	<input type="checkbox"/>

<b>Vision</b>	Left Eye		Right Eye	
	Central	Peripheral	Central	Peripheral
Visual Field Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mild	Moderate	Severe
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Seizures

Please describe

**Medication**

Name	Dose	Strength	Date Started	Date Stopped

**Smoking**

Amount per day

When started

When stopped

**Alcohol**

Type	Amount per day/week
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**Family history of disease:**

Disease	Mother	Father	Grandmother	Grandfather	Brother	Sister
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Supplementation**

List all nutritional supplements – please include brand names.

**Previous Stem Cell Therapy**

Yes      No  
     

Have you had stem cell treatment before?

If Yes

What kind of cells did you receive?

How many cells did you receive?

**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.

Please send any detailed medical reports from your cardiologist and neurologist if available.

**How did you hear about Stem Cells for Hope?**

Internet Search

Personal referral  By whom:

Other  Details:

Please return this form as an attachment to [info@stemcellsforhope.com](mailto:info@stemcellsforhope.com)

Or

**By Fax To: (631) 929 – 3909 C/O: Patient Services**