HANCOCK HEALTHCARE GROUP

DR. LARRY JOHNSON

1510 Hancock Bridge Parkway • Unit 6
Cape Coral, FL 33990
239-574-5559 • Fax 239-574-9454
hancockhealthcaregroup.com

TM-Flow Patient Profile

Today's Date:____________________ Patient Signature: ____________________

Name: ____________________________ D.O.B __________________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Primary Phone: ______________________ Email:____________________

Insurance Policy#: ____________________ Member ID# __________________

Height: __________ Weight: __________

Daily Activity Level: circle one

Very Light	Light	Moderate	Fitness Training	Athlete
stay at home, no activity	Office Activity	2-4 hours of exercise a week	2-4 hours a day	competitor

THE TEST IS CONTRAINDICATED IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

Y / N Patient undergoing external defibrillation.

Y / N Have an implantable pacemaker or cardiac device or insulin pump.

Y / N Bilateral mastectomy.

Y / N Dermatological lesions or calluses on the bottom of your feet.

Y / N An absence of two or more limbs.

Y / N Arterial catheters on arm or leg or an arteriovenous (AV) fistula or shunt.

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Patient Name:______________________________ Date:______________
DOB: ______________ Age:__________ SS#/SIN:______________
Phone Number: ______________ Work:____________ Email:______________
May we Leave Messages/texts on this phone # Yes No
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Home Address: ______________________________
City:______________________ State:__________ Zip:______________
Gender: ☐ Male ☐ Female
Employer Name: ______________________________
Spouse or Patient's Guardian: ______________________________
Whom may we thank for referring you? ______________________________
DNR: ☐ Yes ☐ No (If yes, bring paperwork)
Advanced Directives: ☐ Yes ☐ No (if yes, bring paperwork)
Emergency Contact: ______________________________
In an emergency and the patient is a minor, it is okay for us to treat in absence of parents;

______________________________ ______________
Parent/Guardian Signature Date

Responsible Party (Complete if different from above)
Name of The Person responsible for this account: ______________________________
Relationship to Patient______________________________
Address: ______________________________
Home Phone: ______________________ Cell Phone: ______________
Driver's License # ______________________________
DOB:______________________________
Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical Insurance? ☐ Yes ☐ No (if yes, provide the card)
Name: of the insured______________________________
Relationship to patient______________________ DOB: ______________
Name of Employer______________________ Work Phone: ______________
Address of Employer______________________________
City:______________________ State:__________ Zip:______________
Insurance ID Number: ______________ Group # __________ Union or local #______________
Ins. Co. Address:______________________________
City: ______________________ State:__________ Zip: ______________

HANCOCK HEALTHCARE GROUP

*Patient Name*______________________________ *DOB*___/___/___ *Date*___/___/___ *Age:*_____

Diabetic? Yes/ No Diagnosis Date?____________ **Type Diabetic**________ **HA1C**________ **FBS**________
Implantable devices?______________________ **History of Seizures?**________________

Chief Complaint/Pain in the:______________________ **Unilateral or Symmetrical Bilateral**

1. Onset of Symptoms:______________ Chronic Progressive, Chronic Flareup, Acute Progressive, Acute Flareup
2. Quality of Symptoms:______________________
3. Severity (1 to 10; 10 being the worst):______________________
4. Timing/Frequency of Symptoms:______________________
   a. How many times a Week/Month:______________________
5. Is there a family history of this? **Yes** **No** Describe:______________________
6. Anything inhaled, consumed or exposure-to that caused this?______________________
7. Prescription Meds/OTC, Doctors seen, anything else tried to handle this complaint;______________________
8. Previous Workup / Imagine Done / Where?______________________
9. Subjective Statements about condition:______________________
10. Recent Progression: Better Worse Same
11. Relieving: ______________________
12. Aggravating: ______________________

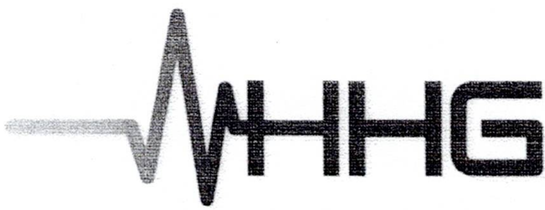
Chief Complaint / Pain in the:______________________ **Unilateral or Symmetrical Bilateral**

1. Onset of Symptoms:______________ Chronic Progressive, Chronic Flareup, Acute Progressive, Acute Flareup
2. Quality of Symptoms:______________________
3. Severity (1 to 10; 10 being the worst):______________________
4. Timing/Frequency of Symptoms:______________________
   a. How many times a Week/Month:______________________
5. Is there a family history of this? **Yes** **No** Describe:______________________
6. Anything inhaled, consumed or exposure-to that caused this?______________________
7. Prescription Meds/OTC, Doctors seen, anything else tried to handle this complaint;______________________
8. Previous Workup / Imagine Done / Where?
   ____
9. Subjective Statements about condition:______________________
10. Recent Progression: Better Worse Same
11. Relieving: ______________________
12. Aggravating: ______________________

Loss of Function / paralysis?	Yes	No
Bowel / bladder incontinence?	Yes	No
Sleep Issues?	Yes	No
Motor Weakness?	Yes	No
TENS Therapy?	Yes	No
Etiology of condition?		
Failed Treatments?		

Stumbling? Holding walls or furniture? Fallen?
____

Insomnia? Yes No______________________



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RST SANEXAS Consent Form

Patient Name:____Date:__________________________

The following treatment plan has been explained to me in general terms, and I understand that:

1. The diagnosis requiring this procedure is:____
2. The nature of this procedure is a vitamin blend mixed with normal Saline and 2% Lidocaine, injected subcutaneously to patient's specific area of pain. Injection area:____
3. The purpose of this procedure is: The subcutaneous vitamin blend injections combined with RST Sanexas electric cell stimulation will decrease pain, as well as stimulate the nerve tissue to regrow and create new axons. Stronger nerves will then allow for increased healing and reduced pain.
4. Material risk of this procedure: As a result of this procedure being performed, there may be a risk of infection, allergic reaction, scars, bleeding, pain at the site of injection, vasovagal reaction, and extremely rare circumstances, seizure, cardiac arrest or death.
5. Practical alternatives to this procedure include: Modalities and therapy.
6. If I choose not to have this procedure performed, my prognosis is UNKOWN.
7. I also understand that this consent form will apply to all sessions of treatment. I understand I should have this treatment performed 2 to 3 times per week as recommended.

I understand that the physician, nurse practitioner, and other medical personnel will rely on statements about my medical history and other corresponding records pertaining to my conditions to determine whether to perform the above procedure which has been explained to me and is recommended as a course of treatment for my condition.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES have been made to me concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary to perform other procedures which are unforeseen, or not known to be needed at the time of this signed consent/authorized the physician and/or nurse practitioner herein to make the decision concerning such procedure, if additional procedures are deemed necessary or appropriate.

I also consent to the diagnostic studies test, local anesthesia, x-rays examinations and any other course of treatment related to the diagnosis or procedure explained herein. Too, I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWEERED TO MY SATISFACTION.

I voluntarily consent to allow any Physician or Nurse Practitioner designated at this clinic, and all medical personnel under the provider's direct supervision to be involved in performing such procedures described or otherwise referred to herein.

____ ____

Signature of Patient | Signature of Physician/Nurse Practitioner

TM Flow System
Patient Questionnaire

Patient Name:______________________________________

Date of Birth:____________________ Today's Date:________________

Please check the appropriate box if you are currently experiencing any of these symptoms, and/or if you have experienced them in the last 7 to 14 days.

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Frequent Urination	☐	☐
Fatigue (Tiredness)	☐	☐
Heartburn	☐	☐
Increased Hunger	☐	☐
Nausea	☐	☐
Numbness & Tingling in Hands or Feet	☐	☐
Vomiting	☐	☐

JDOMETER DYSFUNCTION (SUDOD)		
Burning Sensation - Hands & Feet	☐	☐
Difficulty Digesting Food	☐	☐
Dizziness or Fainting	☐	☐
Exercise Intolerance	☐	☐
Sexual Difficulties	☐	☐
Sweat Abnormalities	☐	☐
Tingling Hands & Feet	☐	☐
Urinary Problems	☐	☐

ENDOTHELIAL DYSFUNCTION (ENDOD)		
Angina (severe chest pain, often spreading to shoulder, arm, neck, back, or jaw)	☐	☐
Chest Pain that goes away with rest	☐	☐
Heartburn	☐	☐
Pain in Calves	☐	☐
Shortness of Breath	☐	☐
Stroke	☐	☐

CARDIOMETABOLIC RISK (CMR)		
Headaches	☐	☐
:zziness	☐	☐
Swelling of Ankles	☐	☐

INSULIN RESISTANCE (IR)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Fatigue (Tiredness)	☐	☐
Increased Hunger	☐	☐

SMALL FIBER SENSORY NEUROPATHY (SFN)		
Burning Sensation - Feet	☐	☐
Painful Contact w/ Socks/Bed Sheets	☐	☐
Pebble or Sand Like Sensation In Shoes	☐	☐
Stabbing or Electrical Shock Sensation	☐	☐
Pins and Needles Sensation in Feet	☐	☐

CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)		
Blurred Vision	☐	☐
Cold, Clammy, Pale Skin	☐	☐
Depression	☐	☐
Dizziness or Lightheadedness	☐	☐
Thirst	☐	☐
Fainting	☐	☐
Fatigue (Tiredness)	☐	☐
Lack of Concentration	☐	☐
Lack of Energy	☐	☐
Nausea	☐	☐
Rapid, Shallow Breathing	☐	☐

PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)		
Blood Clot in a Vein (Venous Thrombosis)	☐	☐
Irregular Heartbeat, too fast/slow (Atrial Fibrillation)	☐	☐

Health History

Chief Complaint:____
____
____

History of Chief Complaint:

Location: ______________________ (Where is the pain/problem?)

Quality: ______________________ (aching, throbbing, stabbing, burning, shooting, etc.)

Severity: ______________________ (Scale of 1-10, 10 is worst pain)

Duration: ______________________ (How long have you had pain?)

Timing:______________________ (Does the pain/problem occur at specific times?)

Context:______________________ (What makes the pain/problem worse/better?)

Influential Factors:______________________________________ (What aggravates the pain? What alleviates the pain?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" / leave blank if you are uncertain.)

Anemia:	YES / NO	Gout:	YES / NO	Back Trouble:	YES / NO
Hepatitis:	YES / NO	Anxiety:	YES / NO	Bladder Infection:	YES / NO
COPD:	YES / NO	Ulcers:	YES / NO	Depression:	YES / NO
High Blood Pressure:	YES / NO	A-Fib:	YES / NO	Bipolar:	YES / NO
Epilepsy:	YES / NO	Migraines:	YES / NO	Kidney Disease:	YES / NO
Fibromyalgia:	YES / NO	Tuberculosis:	YES / NO	Hemorrhoids:	YES / NO
Thyroid Issues:	YES / NO	Incontinence:	YES / NO	Stroke:	YES / NO
Bleeding Tendency:	YES / NO	Cancer:	YES / NO	Seizures:	YES/ NO
Blood Thinners:	YES/NO	Diabetes:	YES/ NO	Hernia:	YES / NO
Asthma:	YES / NO	Pneumonia:	YES / NO	Mood Disorders:	YES / NO
Hives or Eczema:	YES / NO	Glaucoma:	YES / NO	Shingles:	YES / NO
AIDS/HIV:	YES / NO	Bronchitis:	YES / NO	Thrombophlebitis	YES / NO
Arthritis:	YES / NO	Implantable Device	YES / NO	Herpes Simplex	YES / NO
Congestive Heart Failure:	YES / NO				
Deep Vein Thrombosis:	YES / NO				

Have you ever been told you take longer than normal to heal? YES / NO

Any Other Disease/Conditions:______________________________________
____

Previous Surgeries

What Surgery?	When?	Hospital, City, State

Medications: (include nonprescription/ supplements/ vitamins and include dose and how often. may include extra page if needed)
____
____
____

Allergies: (including medication allergies and reactions) ______________________________

Doctors:

Primary Care Physician: ______________________________
Primary Care Physician's phone #: ______________________________
Specialist: ______________________________
Specialist's Phone #: ______________________________

Patient Social History (Circle):

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Rarely	Moderate	Daily	
Use of Drugs:	Never	Type/Frequency: ______			

Family Medical History:

	Age	Disease	Cause of Death
Father			
Mother			
Siblings			
Children			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________
Signature of the Patient, Parent or Guardian Date

Reviewing Provider:

______________________________ ______________
Signature of Provider Date

____
Printed Name of Provider