

# ***Prolotherapy Nashville***

Tennessee's Premiere Prolotherapy Practice

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Suite 150

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ProlotherapyNashville.com

615-506-0536

## ***New Patient Information***

*Thank you for choosing Prolotherapy Nashville for your medical needs. Our goal is to provide you with the best possible medical care. We specialize in treatment of chronic pain and acute injuries caused by damaged connective tissue (tendons and ligaments), using Prolotherapy. For more information about this treatment, including the history of Prolotherapy, conditions which can be treated, and what the treatment consists of, please consult our website(on the letterhead). Our commitment to you is to provide the kind of care that we would desire for our own family, and to provide the best value for your investment in your own health. Thank you for entrusting your care to us. We look forward to getting to know you.*

### ***New Patient Questionnaire***

**Please fill out the enclosed medical questionnaire in full, and remember to bring it to your first visit. There are many questions, but the answer to each of these questions is important to provide the best care for you. Allow yourself plenty of time to answer thoughtfully and completely. No patient will be seen for an initial visit unless these questions are first completed.**

### ***How to Find Us***

**From I-24 from the west, or from I-65 from the north, go through Nashville and take I-65 South. From I-40 from east or west, take I-440 to I-65 South. From I-24 from the south, take I-840 West to I-65 North (toward Nashville). From I-65 from the south, take the Brentwood/Old Hickory Boulevard exit. From whatever direction on I-65, take exit 74B (The Old Hickory Boulevard exit SOUTH of Nashville). There is an OHB exit NORTH of Nashville on I-65---wrong exit!!).**

***From Exit 74B, West on Old Hickory Blvd, from I-65***

**Go west (Right from I-65 from the north, Left from I-65 from the south) on Old Hickory Boulevard. Quickly get in the LEFT lane on OHB, as you will turn left at the next light. At Franklin Road, turn left. From the OHB/FR light, go 0.5 miles south on Franklin Road. On your right you will see a large storefront with a Fresh Market and other businesses. In front of this strip mall, there is a Starbucks. IF YOU DRAW A LINE ACROSS THE STREET FROM THE STARBUCKS, THAT IS OUR 3-STORY BUILDING. There is a sign by the road in front of the Starbucks. Turn LEFT (away from the sign) into our parking lot. You are now driving in front of our building. In front of you is a sign that says 'Building 4'. Park and walk to this sign. Our office entrance, Suite 150, is clearly visible as you walk toward this sign, to the left of the main building entrance.**

**Nearby Hotel Accomodations**

The closest hotels are the Brentwood Courtyard Marriott, and Hilton Suites. Any hotel listed in Brentwood, Tennessee, or in Cool Springs would be very convenient. We are 20 minutes from the airport, 45 minutes in heavy traffic.

**Previous Medical Records**

If you have medical records, test results, and x-rays pertinent to your condition, please bring them with you to your first visit.

**Other Preparation for your First Visit**

Wear loose, comfortable clothing. Your examination and treatment may require putting on a paper gown. It is recommended that you take 1000 mg. of Tylenol (*not* Advil, Aleve, Aspirin, or other anti-inflammatory medication) around the time you arrive in our office if you expect to receive a treatment. It is recommended that you cease taking steroid medication at least a month prior, and anti-inflammatory medication at least one week prior, to receiving a Prolotherapy treatment. In fact, it is preferable to cease these medications completely for the duration of your Prolotherapy treatment, if possible. In the rare situations where sedation is requested, you *must* bring someone to drive for you, and you *must not* drive until the next day. We will try to be prompt and on time. Please arrive for your visit 15 minutes before the appointed time, with the exception of 9 am and 2 pm appointments. Please be precisely on time for these.

**Charges and Payment Policy**

Please review our payment policy before you come, and the information regarding the relationship between Prolotherapy Nashville, PLLC, and insurance companies, Medicare, and Medicaid. You will need to sign the enclosed agreement prior to receiving evaluation and treatment.

**Appointment Cancellation**

Please notify us if you are unable to attend your appointment at least 24 hours in advance. We want to offer these services to people who need them. If you miss an appointment and do not allow us to schedule another patient, then someone is suffering needlessly. Your consideration for your fellow-man is appreciated. A \$100 fee will be levied for missed appointments without proper notification.

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**Thank you for choosing us!**

God designed our bodies to be healthy and strong. Holley and I have personal experience, as well as professional experience, demonstrating to us the healing power of Prolotherapy. Sometimes our body's healing processes need a little help. We look forward to helping you. Thank you for entrusting your care to us.

The Staff of Prolotherapy Nashville, PLLC

## New Patient Information

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**NAME ( Last, First, Middle Initial)**

/ /

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**Date of Birth**

**SSN**

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**ADDRESS (Street, City, State, Zip Code)**

( )

( )

( )

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**Home Phone**

**Work Phone**

**Cell Phone**

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**Employer**

**Email (we do not distribute)**

( )

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**Spouse or Emergency Contact**

**Phone**

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**How did you find us? (Referral Doctor, Former Patient, Internet, etc.)**

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**What do you prefer to be called?**

/ / /

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**Age**

**Marital Status**

**Number of Children**

**Religion (optional)**

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**Occupation**

**Height**

**Weight**

**ALLERGIES: Yes \_\_\_\_\_ None \_\_\_\_\_**

**If the answer is 'Yes', please specify any allergy or adverse reaction to a medication, anesthetic, food, chemical, supplement or vitamin.**

**Agent**

**Type of Reaction**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**ARE YOU ALLERGIC TO FISH, IODINE, OR SHELLFISH? \_\_\_\_\_**

**PATIENT MEDICAL HISTORY**

**CHIEF COMPLAINT/ REASON FOR APPOINTMENT**

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Severity of pain ( 1 – 10 ) Average \_\_\_\_\_ Worst \_\_\_\_\_

**PREVIOUS DIAGNOSES AND TEST RESULTS**

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**PREVIOUS TREATMENTS AND RESULTS**

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**HAS SURGERY BEEN RECOMMENDED? IF SO, WHAT KIND?**

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**HOW AND WHEN DID THE PROBLEM BEGIN?**

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**WHAT MOTIONS OR ACTIVITIES MAKE THE PAIN  
BBETTER OR WORSE?**

**B**

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**W**

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**ARE YOU CURRENTLY UNDER THE CARE OF OTHER  
PRACTITIONERS?**

Name	Treating what condition?
<hr/>	
<hr/>	
<hr/>	

**HAVE YOU TAKEN STEROID OR NON-STEROIDAL ANTI-  
INFLAMMATORY MEDICATION FOR THIS PROBLEM?**

Drug	For how long?	Most recent dose?
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<hr/>		

**LIST JOINTS/RAREAS OF YOUR BODY WHERE YOU  
EXPERIENCE RECURRING OR CHRONIC SYMPTOMS**

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**Location and Type of Symptom**

**R or C    Severity ( 1 – 10)**

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**ASSOCIATED WITH YOUR PROBLEM, DO YOU HAVE...**

**Pain, Numbness, Tingling, Aching, etc. going to other areas. If yes, describe.**

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**Muscle Tightness, Spasm, Trigger Points, Weakness, Limitation of Range of Motion**

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**Headache, Ringing in Ears, Sinus Problems, Visual Problems, Hearing Problems, other head and neck symptoms**

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**Loose joints, unstable joints, cracking and popping, loss of cartilage, unusual flexibility, history of torn meniscus or labrum.**

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**SLEEPING HABITS:    Do you have trouble sleeping? \_\_\_\_\_  
Ave Hours per Night \_\_\_\_\_. Do you take a sleep aid? \_\_\_\_\_**

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Hours of uninterrupted sleep during an average night? \_\_\_\_\_  
Reasons for awakening \_\_\_\_\_

**EATING HABITS:**

Your nutrition is EXCELLENT \_\_\_\_\_ AVERAGE \_\_\_\_\_ POOR \_\_\_\_\_

You take supplements and vitamins? Yes \_\_\_\_\_ No \_\_\_\_\_.

Have you seen a nutrition professional? Yes \_\_\_\_\_ No \_\_\_\_\_.

**LIFESTYLE:** Do you smoke? \_\_\_\_ Use other tobacco products? \_\_\_\_

Have you ever smoked or used tobacco? \_\_\_\_\_ Years? \_\_\_\_\_

Alcohol use? \_\_\_\_\_ Average drinks per week? \_\_\_\_\_

Recreational Drug use—current? \_\_\_\_\_ past? \_\_\_\_\_

**EXERCISE AND ACTIVITY:** How many times per week? \_\_\_\_\_

Activity and duration \_\_\_\_\_

Consistent or inconsistent? \_\_\_\_\_

**ARE YOU CURRENTLY OR FORMERLY INVOLVED IN:**

Martial Arts \_\_\_\_\_ Kickboxing \_\_\_\_\_ Yoga \_\_\_\_\_ Gymnastics \_\_\_\_\_ Boxing \_\_\_\_\_

Cheerleading \_\_\_\_\_ Triathelons \_\_\_\_\_ Marathons \_\_\_\_\_ Professional sports \_\_\_\_\_

Olympic level amateur sports \_\_\_\_\_ Club level amateur sports \_\_\_\_\_ MMA \_\_\_\_\_

**HORMONE BALANCE:**

Are you on hormone replacement therapy? \_\_\_\_\_ How Long? \_\_\_\_\_

Which hormones? \_\_\_\_\_

Have your Testosterone ever been tested? \_\_\_\_\_ Low? \_\_\_\_\_

*(Circle if 'yes')* Past menopause Problems with adrenal gland

Hysterectomy Problems with thyroid Problems with pituitary gland

Have you or a close relative had *Breast Cancer*

Have you had *Ovarian Cancer, Uterine Cancer, or Prostate Cancer?*

If male, what is your PSA? \_\_\_\_\_ When obtained? \_\_\_\_\_

*During the last year have you noticed...(Circle if 'yes')*

Decreased energy

Decreased Libido

Weight Gain

Loss of strength

Mood changes

Depression

Loss of endurance

Erection problems

Irritability

Sleeping more

Sleeping less

Memory loss

Hot flashes

Hard to concentrate

Awake tired or exhausted

Difficulty handling stressful situations

*True or False:* I was doing fine until \_\_\_\_\_ years ago. Now my whole body seems to be falling apart? True \_\_\_\_\_ False \_\_\_\_\_

**IMMUNE SYSTEM:**

Have you ever been told that you have: Fibromyalgia \_\_\_\_\_

Chronic Fatigue Syndrome \_\_\_\_\_ Lyme Disease \_\_\_\_\_  
Systemic Candida infection \_\_\_\_\_ Hepatitis B, C, or D \_\_\_\_\_  
Food Allergies \_\_\_\_\_ Severe seasonal allergies \_\_\_\_\_

Have you ever taken an immunosuppressive medication? \_\_\_\_\_  
Have you ever had cancer chemotherapy? \_\_\_\_\_

Do you have frequent stomach aches, diarrhea, or bloating? \_\_\_\_\_  
Do you get stomach symptoms from any food? \_\_\_\_\_  
Have you been told that you have Irritable Bowel Syndrome? \_\_\_\_\_

If you have food allergies, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**KNOWLEDGE OF PROLOTHERAPY:**

I have: read the ProlotherapyNashville website in some detail \_\_\_\_\_  
received Prolotherapy treatment by another physician \_\_\_\_\_  
read one or more books on Prolotherapy \_\_\_\_\_  
reviewed other websites in some detail \_\_\_\_\_  
heard about this treatment in detail from a friend \_\_\_\_\_  
heard about this treatment from medical professional \_\_\_\_\_  
what kind of practitioner? \_\_\_\_\_  
heard about this treatment from a media source \_\_\_\_\_  
heard about this treatment from Dr. Johnson's printed materials  
which ones? \_\_\_\_\_

How knowledgeable are you about this treatment:  
Very \_\_\_\_\_ Fairly \_\_\_\_\_ Barely \_\_\_\_\_

What resources, books, websites, etc., did you find most helpful?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What questions do you have about this treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

\_\_\_\_\_

	Yes	No	When Diagnosed?
Diabetes	_____	_____	_____
Seizure Disorder	_____	_____	_____
Stroke	_____	_____	_____
Heart Attack	_____	_____	_____
Angina	_____	_____	_____
High Blood Pressure	_____	_____	_____
Emphysema	_____	_____	_____
Asthma/Bronchitis	_____	_____	_____
Chronic Sinusitis	_____	_____	_____
Frequent colds	_____	_____	_____
Migraines	_____	_____	_____
Ringling in ears	_____	_____	_____
Blurred Vision	_____	_____	_____
Whiplash	_____	_____	_____
Arthritis	_____	_____	_____
Disc rupture	_____	_____	_____
Degenerative disc disease	_____	_____	_____
Rotator Cuff injury	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Adrenal Disorder	_____	_____	_____
Pituitary Disorder	_____	_____	_____
High Cholesterol	_____	_____	_____
Bleeding problems	_____	_____	_____
Hepatitis	_____	_____	Type _____
Chronic Fatigue	_____	_____	_____
Fibromyalgia	_____	_____	_____
Interstitial Cystitis	_____	_____	_____
Elevated PSA	_____	_____	_____
Other hormone problem	_____	_____	_____
Gastrointestinal problems	_____	_____	_____
Depression	_____	_____	_____
Other Psychiatric illness	_____	_____	_____
HIV/AIDS	_____	_____	_____

List any accident or injury with symptoms lasting longer than one month: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you require multiple injections of local anesthetic when you go to the dentist? Or have you had problems getting 'numb enough' during other local anesthetic procedures?

Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS THAT  
YOU ARE CURRENTLY TAKING**

#	DATE	PRODUCT NAME	BRAND NAME	REASON	DOSAGE	FREQUENCY
1						
2						
3						
4						
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## ***Prolotherapy Nashville Charges and Payment Policy***

*Charge for initial office visit ranges between*        **\$150 and \$250.**  
*Charge for follow-up visit ranges between*        **\$45 and \$95**  
*Prolotherapy treatments range in cost between*    **\$90 and \$900**

**At your initial visit, you will receive separate charges for the office visit, and for Prolotherapy treatment, if administered.**

**No charge for follow-up visit if Prolotherapy treatment is also received.**

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**Payment is due at the time of service. There will be no exceptions to this policy.**

**Visa, Mastercard, Personal Checks, and Cash are accepted.**

**Prolotherapy Nashville does not participate in Medicare or Medicaid, and Prolotherapy is specifically noted by Medicare and Medicaid to be a non-covered service. If you have Medicare or Medicaid, you must sign a waiver acknowledging that these services will not be covered by Medicare or Medicaid, nor will they be covered by a Medigap or co-insurance policy, and agreeing to pay the fees charged by Prolotherapy Nashville.**

**Insurance is not accepted. We do not participate in any insurance plans, and will not accept payment from your company. If your insurance plan pays for Prolotherapy treatments, or office visits, you may file for reimbursement from your company. We will give you the form with the correct codes to file. Unfortunately, our staff will not be able to contact your insurance company for the purpose of ‘problem solving’. If your company requires treatment records, you may provide us with a self-addressed, stamped envelope and we will mail a copy of these records to you.**

***It is possible that any, or all, of your billed services may not be reimbursable by your insurance company. Discounted reimbursement by your insurance company (their arbitrary assignment of ‘reasonable and customary charges’, ‘medically necessary,’ etc.) reflects an agreement between the policyholder and company. This in no way influences the charges or payment due to Prolotherapy Nashville for services rendered.***

**Prices for office visits, treatments, and supplies are subject to change without notice.**

**I understand the fees and payment policies of Prolotherapy Nashville and I agree to be bound by these policies:**

**Date\_\_\_\_\_ . Name\_\_\_\_\_.**

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