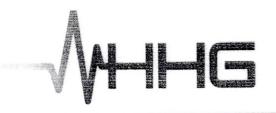


## DR. LARRY JOHNSON

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

#### TM-Flow Patient Profile

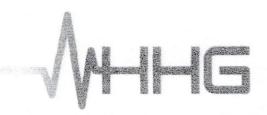
Today's [	Date:		Patient Signature:					
Name: _			D.O.B					
Address:								
City:		one of the second secon	State:	Zip:				
Primary	Phone:		Em	ail:				
Insuranc	e Policy#:		Mem	ber ID#				
Height:		Weight: _						
Daily	Activity Le	evel: circle one						
				Fitness Training	Athlete			
stay at hon	ne, no activity	Office Activity	2-4 hours of exercise a week	2-4 hours a day	competitor			
THE TES	ST IS CONTRA	AINDICATED IF YO	OU HAVE ANY OF THE FOL	LOWING CONDITIONS:				
Y/N	Patient und	ergoing 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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Dationt Nama:		Date:	
Patient Name:	A a a :	SS#/SIN·	
Dona Number	Work:	Email:	
1	toxto on this phone II Yes	IV()	
Chack Appropriate Box.	1Minor   Single   Married	☐ Divorced ☐ Widowed ☐ Separated	
	Sta	ate:Zip:	
City:	Temale		
Employer Name:			
Comment of Dationt's Cuard	lian.		
Mhom may we thank for re	eferring VOLI?		
DNR: Yes No (If	ves bring paperwork)		
Advanced Directives: T	Yes ☐ No (if yes, bring pape	erwork)	
Advanced Directives.	163 [ 140 (11 ) 00, 219 pape	,	
In an emergency and the	natient is a minor, it is okay for	or us to treat in absence of parents;	
in airemergency and the p	Janeth le a miner, a le sues,		
		,	
Parent/Guardian Signature	0	Date	
Name of The Person resp	omplete if different from a consible for this account:		
Address:			
Home Phone:	Ce	ell Phone:	
Driver's License #			
DOB:			
Is the person currently as	patient at our office?  Yes	□ No	
ie the person camera,			
	_		
Do you have any Med	ical Insurance?	☐ No (if yes, provide the card)	
Relationship to patient		DOB: Work Phone:	
Name of Employer		Work Phone:	
Address of Employer		7	
City:	State:	Zip:	
Insurance ID Number:	Group # _	Zip:Union or local #	
Ins. Co. Address:			
City:	State:	Zip:	



Chief Complaint/Pain in the Unilateral or Symmetrical Bilateral  1. Onset of Symptoms: Chronic Progressive, Chronic Flareup, Acute Progressive, Acute Flared  2. Quality of Symptoms: Chronic Progressive, Chronic Flareup, Acute Progressive, Acute Flared  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: Chronic Progressive, Chronic Flareup, Acute Progressive, Acute Flare  13. Onset of Symptoms:  14. Timing/Frequency of Symptoms:  25. Severity (1 to 10, 10 being the worst):  16. Timing/Frequency of Symptoms:  26. Anything inhaled, consumed or exposure-to that caused this?  77. Prescription Meds/OTC, Doctors seen, anything else tried to handle this complaint;  88. Previous Workup / Imagine Done / Where?  99. Subjective Statements about condition:  100. Recent Progression: Better Worse Same  111. Relieving:  122. Aggravating:  133. Recent Progression: Better Worse Same  144. Relieving:  155. Recent Progression: Better Worse Same  156. Recent Progression: Better Worse Same  167. Recent Progression: Better Worse Same  178. Relieving:  189. Aggravating:  199. Subjective Statements about condition:  100. Recent Progression: Better Worse Same  110. Recent Progression: Better Worse Same  111. Relieving:  122. Aggravating:  123. Aggravating:  134. Relieving:  145. Relieving:  156. Recent Progression: Better Worse Same  167. Recent Progression: Better Worse Same  179. Recent Progression: Better Worse Same  189. Relieving:  199. Recent Progression: Better Worse Same  199. Relieving:  190. Recent Progression: Better Worse Same  190. Recent Progression: Better Worse Same  190. Recent Progression: Better	Diabeti	c? Yes/ No Diagnosis Date?_		Ту	oe Diabetic	HA1C	FBS			
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10. Recent Progression: Better Worse Same  11. Relieving:  12. Aggravating:  Loss of Function / paralysis? Yes No Stumbling? Holding walls or furniture? F Bowel / bladder incontinence? Yes No Sleep Issues? Yes No Insomnia? Yes No Wotor Weakness? Yes No TENS Therapy? Yes No Etiplogy of condition?										
11. Relieving:  12. Aggravating:  Loss of Function / paralysis? Yes No Stumbling? Holding walls or furniture? F Bowel / bladder incontinence? Yes No Sleep Issues? Yes No Insomnia? Yes No Motor Weakness? Yes No TENS Therapy? Yes No Etiplogy of condition?	10									
Loss of Function / paralysis?  Sowel / bladder incontinence?  Yes No Sleep Issues?  Yes No Insomnia? Yes No  TENS Therapy?  Yes No  Tellogy of condition?		-								
Loss of Function / paralysis?  Bowel / bladder incontinence?  Yes No Sleep Issues?  Yes No Insomnia? Yes No  TENS Therapy?  Yes No  Tensom Insom	11	. Relieving:								
Bowel / bladder incontinence? Yes No Sleep Issues? Yes No Insomnia? Yes No Motor Weakness? Yes No TENS Therapy? Yes No	12	. Aggravating:								
Bowel / bladder incontinence? Yes No Sleep Issues? Yes No Insomnia? Yes No Motor Weakness? Yes No TENS Therapy? Yes No Etiplogy of condition?										
Sleep Issues?         Yes         No         Insomnia? Yes         No           Motor Weakness?         Yes         No           TENS Therapy?         Yes         No					Stumbling?	? Holding wa	ills or furniture? Faller			
Motor Weakness? Yes No TENS Therapy? Yes No					Incompie 2	Voc. No.				
TENS Therapy? Yes No										
Etiology of condition?										
		Etiology of condition?								



\_Date:\_\_\_

#### DR. LARRY JOHNSON

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

#### **RST SANEXAS Consent Form**

Patient Name:\_\_\_\_

The following treatment plan has been explained to me in general terms, and I understand that:
<ol> <li>The diagnosis requiring this procedure is:         <ul> <li>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:</li> </ul> </li> <li>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.</li> <li>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.</li> <li>Practical alternatives to this procedure include: Modalities and therapy.</li> <li>If I choose not to have this procedure performed, my prognosis is UNKOWN.</li> <li>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.</li> </ol>
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 bo	x if you a	are curre enced th	ently experiencing any of these symptoms, a nem in the last 7 to 14 days.	and/or		
AUTONOMIC NERVOUS SYSTEM					7-14	
DYSFUNCTION (ANSD)	Today	7-14 Dave	INSULIN RESISTANCE (IR) Blurred Vision	Today	Days	
Blurred Vision						
Elevated Blood Sugar			Elevated Blood Sugar Extreme Thirst			
Extreme Thirst			Fatigue (Tiredness)	_		
Frequent Urination			Increased Hunger	_		
Fatigue (Tiredness)			mcreased nunger			
Heartburn			SMALL FIBER SENSORY NEUROPATH	JV (CEN	<u></u>	
Increased Hunger			Burning Sensation - Feet	and ordered a sort one surround	-	
Nausea	0		Painful Contact w/ Socks/Bed Sheets			
Numbness & Tingling in Hands or Feet	_		Pebble or Sand Like Sensation In Shoes			
Vomiting			Stabbing or Electrical Shock Sensation			
	us		Pins and Needles Sensation in Feet			
JDOMETER DYSFUNCTION (SUDOD	)		This and recedes densation in 1 eet			
Burning Sensation - Hands & Feet	, –		CARDIOMETABOLIC AUTONOMIC			
Difficulty Digesting Food			NEUROPATHY (CAN)			
Dizziness or Fainting	_		Blurred Vision			
Exercise Intolerance			Cold, Clammy, Pale Skin			
Sexual Difficulties			Depression	0		
Sweat Abnormalities			Dizziness or Lightheadedness		_	
Tingling Hands & Feet			Thirst	0		
Urinary Problems			Fainting	_		
NATURAL DESCRIPTION OF THE PROPERTY OF THE PRO			Fatigue (Tiredness)	0		
<b>ENDOTHELIAL DYSFUNCTION (ENDO</b>	D)		Lack of Concentration	_	_	
Angina (severe chest pain, often spreadir			Lack of Energy	_	_	
to shoulder, arm, neck, back, or jaw			Nausea		0	
Chest Pain that goes away with rest			Rapid, Shallow Breathing		0	
Heartburn			•	_	_	
Pain in Calves			PLETHYSMOGRAPHY CARDIOVASCU	LAR		
Shortness of Breath			DISEASE (PTG CVD)			
Stroke			Blood Clot in a Vein (Venous Thrombosis Irregular Heartbeat, too fast/slow	6) 🗆		
CARDIOMETABOLIC RISK (CMR)			(Atrial Fibrillation)			
Headaches			V	_	u	
ziness						
Swelling of Ankles						

Health History					
Chief Complaint:					
History of Chief Co	mplaint:				
Location:			Quality:		
(Where is t	he pain/problem?)		(aching,	throbbing, stabbing, burn	
Severity:(Scale of 1	-10, 10 is worst pain)	**************************************	Duration:	ow long have you had pa	ain?)
Timing:			Context:		
(Does the pai	n/problem occur at spec	cific times?)	(W	hat makes the pain/prob	lem worse/better?)
Influential Factors:					
(What aggr	ravates the pain? What	alleviates the pain	?)	127	
Past Medical Hist	orv				
(Have you ever had th	e following: (circle "yes"	or "no" / leave bla			
Anemia: YES / NO		Gout:	YES / NO	Back Trouble:	YES / NO
Hepatitis: YES / NO COPD: YES / NO		Anxiety: Ulcers:	YES / NO YES / NO	Bladder Infection: Depression:	YES / NO YES / NO
High Blood Pressure:	YES / NO	A-Fib:	YES / NO	Bipolar:	YES / NO
Epilepsy:	YES / NO	Migraines:		Kidney Disease:	YES / NO
Fibromyalgia:	YES / NO	Tuberculosis:		Hemorrhoids:	YES / NO
Thyroid Issues:		Incontinence:		Stroke:	YES / NO
Bleeding Tendency: Blood Thinners:		Cancer:	YES / NO	Seizures:	YES/ NO
Blood Thinners: Asthma:	YES/NO YES / NO	Diabetes: Pneumonia:	YES/NO YES/NO	Hernia: Mood Disorders:	YES / NO 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		Herpes Simplex	YES / NO
Congestive Heart Failu Deep Vein Thrombosis		Device	YES / NO		
	old you take longer than	normal to heal?	YES / NO		
Any Other Disease/Co	onditions:				
Previous Surgerion What Surgery?	es	When	?	Hos	pital, City, State
Medications: (inclu	ude nonprescription/ sup	oplements/ vitamir	ns and include	dose and how often. ma	y include extra page
if needed)					

Allergies: (incl	uding medicat	ion allergies a	nd reactions)			
					-	
<b>Doctors:</b> Primary Care Phy	ysician:					
Primary Care Phy Primary Care Phy Specialist:	ysician's phone	e #:				
Specialist: Specialist's Phon	ne #:					
Patient Socia Marital Status: Use of Alcohol: Use of Tobacco: Use of Drugs:	Single Never	Married Rarely Rarely	Separated Moderate Moderate	Divorced Daily Daily	Widowed	
Family Medic	al History:					
Father	Age	Dise	ase	Caus	se of Death	
Mother						
Siblings	-	-				
			***************************************			
	-					
Children						
		-				
understand to responsibility	hat providir / to inform t	ng incorrec the doctor'	t information s office of an	can be dang y changes in	re been accurate perous to my hea my medical stat ces I may need	Ith. It is my
Signature of the	Patient, Parent	t or Guardian	2		Date	
Reviewing Provide	der:					
Signature of Prov	vider			<del></del>	Date	
Printed Name of	Provider					