CARE Natural Wellness Center | Get Healthy. Stay Healthy. *Naturally.*

Knee Pain Intake Form

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name: _____ **Social Security #:** _____ **Date:** _____

Date of Birth: _____ **Age:** ____ **Sex:** ____ **Marital Status:** ____ **# of Children:** ___

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Spouse Name: _____ **Phone Number:** _____

Your Occupation: _____ **Retired:** Yes☐ No☐

Current or Previous Work | Clerical: Yes☐ No☐ **Light Labor:** Yes☐ No☐

Moderate Labor: Yes☐ No☐ **Heavy Labor:** Yes☐ No☐

In Case of Emergency Contact: _____ **Phone Number:** _____

TELL US ABOUT YOUR PAST HEALTH

Please check all that apply

- ☐ Lower Back Pain
- ☐ Leg or Foot Pain/Numbness
- ☐ Spinal Fractures
- ☐ Spinal Stenosis
- ☐ Spinal Arthritis
- ☐ Sciatica
- ☐ Neck Pain
- ☐ Herniated Disc
- ☐ Diabetes (A1C = _____)
- ☐ Hand Problems
- ☐ Neuropathy
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ Vascular Leg Problems
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Vascular Surgery _____
- ☐ Shingles
- ☐ Knee Surgery
- ☐ Kidney issues or Dialysis
- ☐ Gout
- ☐ Hip Surgery
- ☐ Leg Fractures
- ☐ Joint Replacement
- ☐ Foot Surgery

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Patient Name _____.

PLEASE LIST ANY MEDICATION AND/OR VITAMINS YOU ARE CURRENTLY TAKING OR ATTACH MED LIST:

1. _____ 9. _____
2. _____ 10. _____
3. _____ 11. _____
4. _____ 12. _____
5. _____ 13. _____
6. _____ 14. _____
7. _____ 15. _____
8. _____ 16. _____

Name of Your Primary Care Physician _____

May We Contact Them With Updates Regarding Your Treatment? Yes ☐ No ☐

Please List Below Any Back, Knee, or Leg Surgeries You've Had?

Have You Had an EMG Performed on Your Legs/Feet? Yes ☐ No ☐ When?_____

Do You Exercise Regularly? Yes ☐ No ☐ What?_____

Are Your Symptoms Worse at Night? Yes ☐ No ☐ Around What Time?_____

PRESENT HEALTH CONDITIONS

01 **What Kind of Problem(s) Are You Having?**

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Patient Name _____.

02 **On A Scale, How Would You Rate Your Symptoms (10 Is The Worst)**

1 2 3 4 5 6 7 8 9 10

When did this begin? _____

What makes it better? _____

What makes it worse? _____

03 **How Would You Describe Your Symptoms?**

- ☐ Stabbing
- ☐ Sharp
- ☐ Stings
- ☐ Electric-Shocks
- ☐ Ache
- ☐ Cold
- ☐ Numbness
- ☐ Tingling
- ☐ Tiredness
- ☐ Swelling
- ☐ Cramping
- ☐ Burning

04 **Is This Condition Interfering With Any of the Following?**

- ☐ Sleep
- ☐ Walking
- ☐ Work
- ☐ Standing
- ☐ Daily Activities
- ☐ Chores

CURRENT PAIN LEVELS

01 **How Would You Describe Your Average Knee Pain Over the Past Week?**

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

02 **Please Indicate What You Consider to be an Acceptable Level of Pain After Completion of the Treatment, If You Have to Accept Some Pain?**

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

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Patient Name _____.

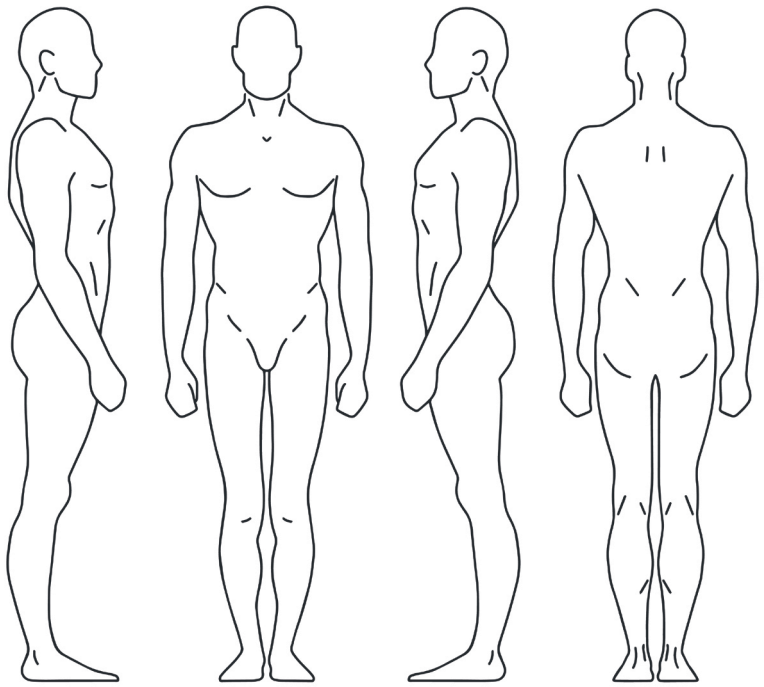
03 **Please Indicate on These Drawings the Body Area(s) Where You Are Currently Experiencing Symptoms:**

Use the Following Colors:

Pain = Blue

Numbness/Tingling = Red

Stiffness = Green



04 **Which of the Following is True for Your Condition:**

☐ It's getting better on its own ☐ It's staying the same ☐ It's getting worse as time goes by

05 **List any Daytime Activities (You Used to be Able to Do When You Were Feeling Better) That Are Now Limited:**

_____

_____

_____

06 **List the Three Main "Health Goals" That You Would Like to Accomplish:**

1. _____
2. _____
3. _____

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Patient Name _____.

STATEMENT

A I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.

B I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Name: _____ **Signature:** _____ **Date:** _____

How Did You Hear About our Office?

_____

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Patient Name _____.

WALKING SCALE QUESTIONNAIRE

These questions ask about limitations to your walking due to knee pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

In the past 2 weeks, how much has your knee pain...	Not at all	A little	Moderately	Quite a bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up or down stairs?	1	2	3	4	5
Made standing when doing things more difficult?	1	2	3	4	5
Limited your balance when standing or walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors (e.G. Holding on to furniture, using a cane, etc.)?	1	2	3	4	5
Made it necessary for you to use support when walking outdoors (e.G. Using a cane or walker, etc.)?	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

Thank You For Completing This Questionnaire
Walking Scale Disability Score: < 13 Normal, 13-27 Mild, 28-45 Moderate, >63 Severe Disability
Blueprint To Healthcare/Weight Loss/Neuropathy/Knee Pain

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Patient Name _____.

KNEE PAIN PROGRAM QUALIFICATION QUESTIONNAIRE

Please answer all the following questions by circling one answer per question

01 **Do you experience knee pain?** Right ☐ Left ☐ Both ☐

02 **Do you experience knee pain at rest?** Yes ☐ No ☐

03 **Do you have knee osteoarthritis confirmed by imaging?** Yes ☐ No ☐ Unsure ☐

04 **Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months?** Yes ☐ No ☐

05 **Do you have morning knee stiffness lasting 30 minutes or less?** Yes ☐ No ☐

06 **Do you experience a grinding sensation with knee movement?** Yes ☐ No ☐

07 **Have you tried pain and/or anti-inflammatory medications (i.e.: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief?** Yes ☐ No ☐

08 **Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief?** Yes ☐ No ☐

09 **Have you attempted to lose weight to help with your knee pain?** Yes ☐ No ☐

10 **Have you used a knee brace without long-term relief?** Yes ☐ No ☐

11 **Has your doctor ever drained excess fluid from the affected knee(s)?** Yes ☐ No ☐

12 **Have you tried steroid/cortisone injection(s) to the knee without long-term relief?** Yes ☐ No ☐

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN TO THE FRONT DESK.

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Quality of Life Survey

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 **How have you taken care of your health in the past?**

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 **How did the previous method(s) work out for you?**

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 **How have others been affected by your health condition?**

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

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Patient Name _____.

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

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Patient Name _____.

08 **What are you most concerned with regarding your problem?**

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

10 **What would be different/better without this problem? Please be specific.**

11 **What do you desire most to get from working with us?**

12 **What would that mean to you?**

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Patient Name _____.

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____