

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

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

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?

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?

- | | | |
|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Ache | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Cold | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Stings | <input type="checkbox"/> Numbness | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Electric-Shocks | <input type="checkbox"/> Tingling | <input type="checkbox"/> Burning |

04 Is This Condition Interfering With Any of the Following?

- | | | |
|----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> 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

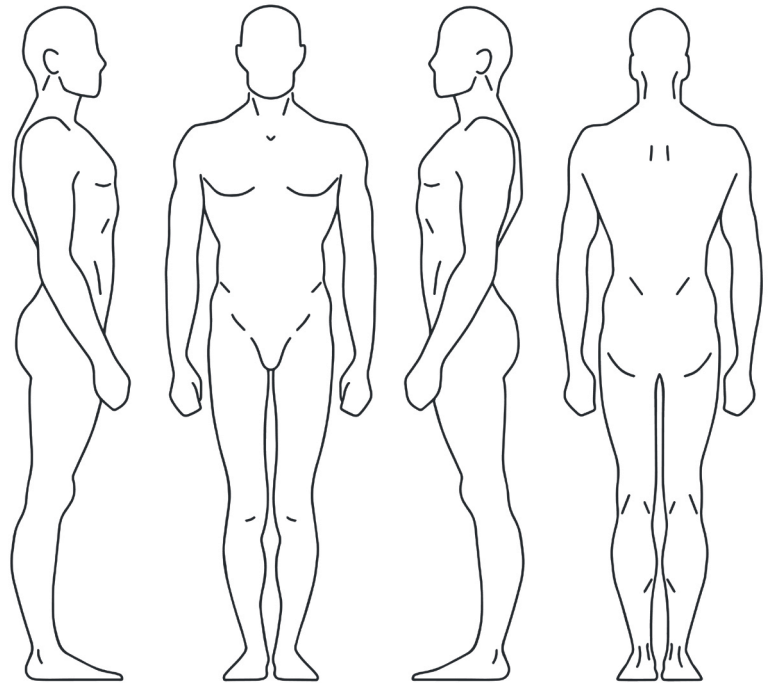
03 Please Indicate on These Drawings the Body Area(s) Where You Are Currently Experiencing Symptoms:

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. _____

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?



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

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.**

Quality of Life Survey

Company Information: _____

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?

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

03 How have others been affected by your health condition?

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |

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

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

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

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

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.

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?

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 _____