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

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

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

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:

_____

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?

- ☐ 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

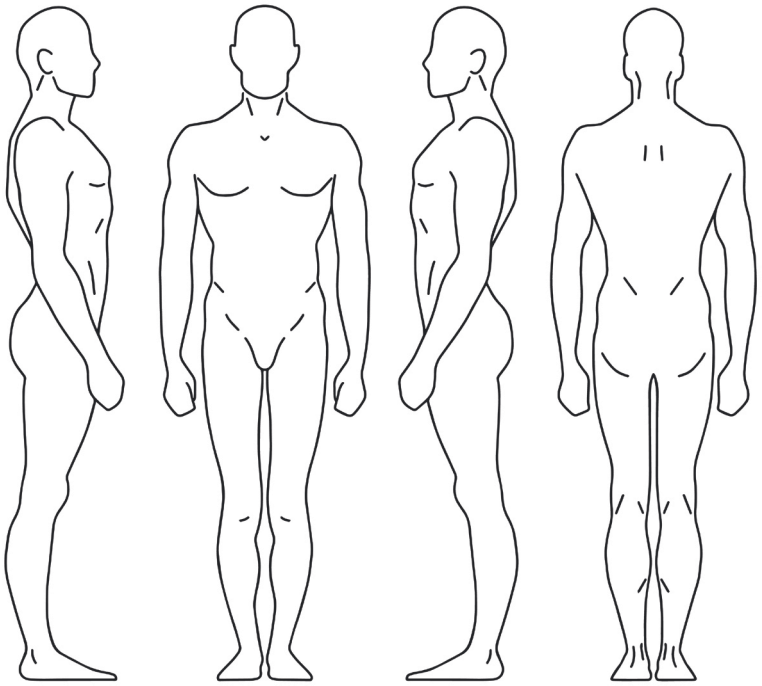
03 Please Indicate on These Drawings the Body Area(s) Where You Are Currently Experiencing Symptoms:

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

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

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.