KNEE PAIN APPLICATION

Name: ______________________________ **Date:** ______________

Nickname: ______________ **Date of Birth:** __________ **Age:** ______ **Sex: M** ☐ **F** ☐

Address: ____

City: ____________________ **State:** __________ **Zip:** __________

Mobile Phone #: ____________________ **Home Phone #:** ____________________

Email Address: ____

Occupation (Current or Previous): ____________________ **Retired: Yes / No**

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: ______________ **Marital Status: S M D W # of Children:** ______

In Case of Emergency: Contact Name: ______________ **Phone #:** ______________

How did you hear about our office? ______________________________

What is your main health concern / condition coming in today? ______________________

When did this begin? ______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

How would you describe your symptoms? *(Circle any that apply)*

| Limping | Stiff | Swelling | Stabbing | Sharp | Grinding | Throbbing |

| Ache | Weakness | Tiredness | Electric Shocks | Cold | Burning |

| Numbness | Cramping | Dead Felling | Stings | Pins & Needles |

Is this condition interfering with any of the following? *Circle any that apply)*

| Daily Activities | Relationships | Hobbies | Exercise | Standing | Walking | Lifting | Sleep | Work |

Frequency of your Pain:

Constant (76 – 100&) ____ Frequent (51 – 75%) ____ Occasional (25 – 50%) ____ Intermittent (24% or less) ___

On average what level would you rate your overall knee pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

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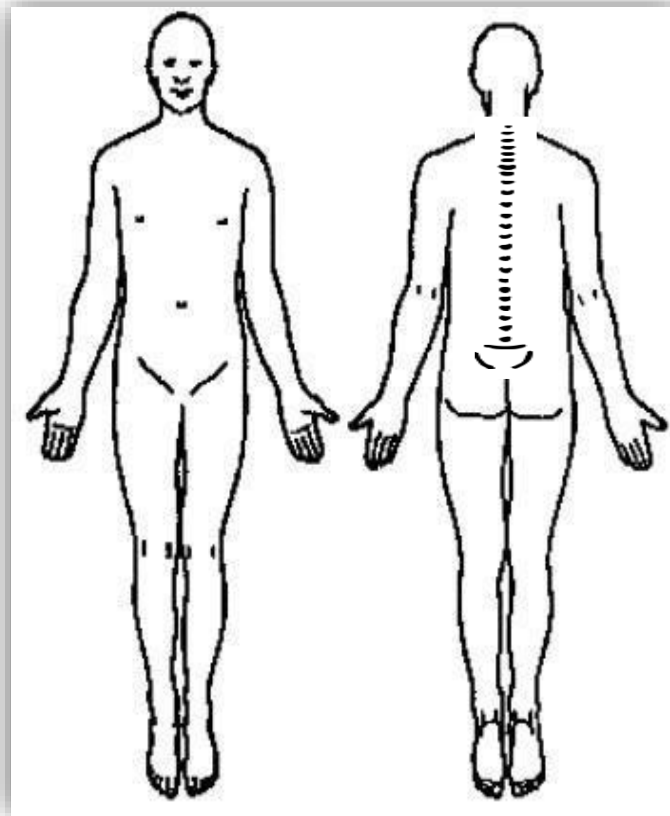
Please indicate on this drawing the area(s) where you are currently experiencing symptoms:



Has your knee pain interfered with daily activities (walking, going up / down stairs, prolonged standing, sit to stand) for at least 6 months? ____

Have you tried pain and / or anti-inflammatory medications (i.e. Tylenol, Aspirin, Aleve, Advil, Meloxicam, Pain Creams) for at least 3 months without gaining long term relief from your symptoms? If yes, what have you tried?

____

____

Have you tried physical therapy for the affected knee(s) without long-term relief from your symptoms?

____

Have you used a knee brace without long-term relief of your symptoms? What type of knee brace?

____

____

Have you tried Steroid / Cortisone Injection(s) to the knee without long-term relief? How many? ______________

____

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Please list below any Back, Knee, or Leg surgeries you've had and the dates: ______________________________

____

Have you had an MRI performed on your Legs/Knees/Feet? ☐ **No** ☐ **Yes, when?** ________________________

Has your doctor ever drained excess fluid from your affected knee(s)? ____________________________________

COMPREHENSIVE HEALTH HISTORY

☐ **Low Back Pain**	☐ **Vascular Leg Problems**	☐ **Heart Attack**	☐ **Shingles**
☐ **Sciatica**	☐ **Vascular Surgery(s)**	☐ **Stroke**	☐ **Kidney Disease**
☐ **Leg or Foot Pain/Numbness**	☐ **Joint Replacement**	☐ **High Blood Pressure**	☐ **Dialysis**
☐ **Neck Pain**	☐ **Knee Surgery(s)**	☐ **High Cholesterol**	☐ **Gout**
☐ **Hand Pain/Numbness**	☐ **Leg Fracture**	☐ **Cancer**	☐ **Other:** __________________
☐ **Herniated/Bulging Disc**	☐ **Foot Surgery(s)**	☐ **Neuropathy**	
☐ **Spinal Arthritis**	☐ **Spinal Surgery(s)**	☐ **Diabetes (last A1c=_____)**	

Please list any / all prescription medications or vitamins you are currently taking (or you may attach a list):

Name	Dosage per Day

Name of your Primary Care Physician: ________________________________ **Clinic:** ______________________

May we contact them with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to ________________________.
- I understand that ___________________________________ cannot file the knee treatments to insurance at this time.
- ____________________________________ will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patient's responsibility to contact their own insurance.

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.

Signature: ____ Date: ___________________________

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FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? ____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

____

____

____

____

____

Has what you've done to date for your condition helped?

☐ Yes, a lot **☐ Yes, some** **☐ No, not at all** **☐ Indifferent**

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1.____

2.____

3.____

4.____

5.____

What is your honest vision of your life in the next few years if this problem continues to progress? ____

____

____

What would be different &/or better in your life without this problem? Please be specific.

____

____

____

What is your biggest fear if this condition continues to progress? __________________________

____

____

____

What would success mean to you in our office? ____

____

____

____