Application for Knee Pain Treatment (Please Print Clearly)

Name:			Social Security#:		Date:
Date of Birth:	Age:	Sex: M F	Marital Status M S D W		# of children:
Address:					
City:			State:	Zip:	
Home Phone #:			Cell #:		
E-mail Address:					
Spouse's Name:					
Occupation (Current or Previous)					Retired: Y N
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N	
In Case of Emergency Contact Name			Phone Number:		

TELL US ABOUT YOUR PAST HEALTH:

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

NAME OF YOUR PRIMARY CARE PHYSICIAN: ____________________________________

MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT? □ YES □ NO

HAVE YOU HAD AN **EMG** PERFORMED ON YOUR LEGS/FEET? □ NO □ YES - WHEN:

DO YOU EXERCISE REGULARLY? □ NO □ YES - WHAT:

ARE YOUR SYMPTOMS **WORSE AT NIGHT**? □ NO □ YES – AROUND WHAT TIME?

WHAT KIND OF PROBLEM(S) ARE YOU HAVING:?
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:

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

WHAT DO YOU THINK IS CAUSING YOUR PROBLEM:

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)						
WORK	SLEEP	DAILY ROUTINE	CHORES	WALKING	STANDING	SHOPPING

How would you describe your average knee pain over the past week?

No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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 **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

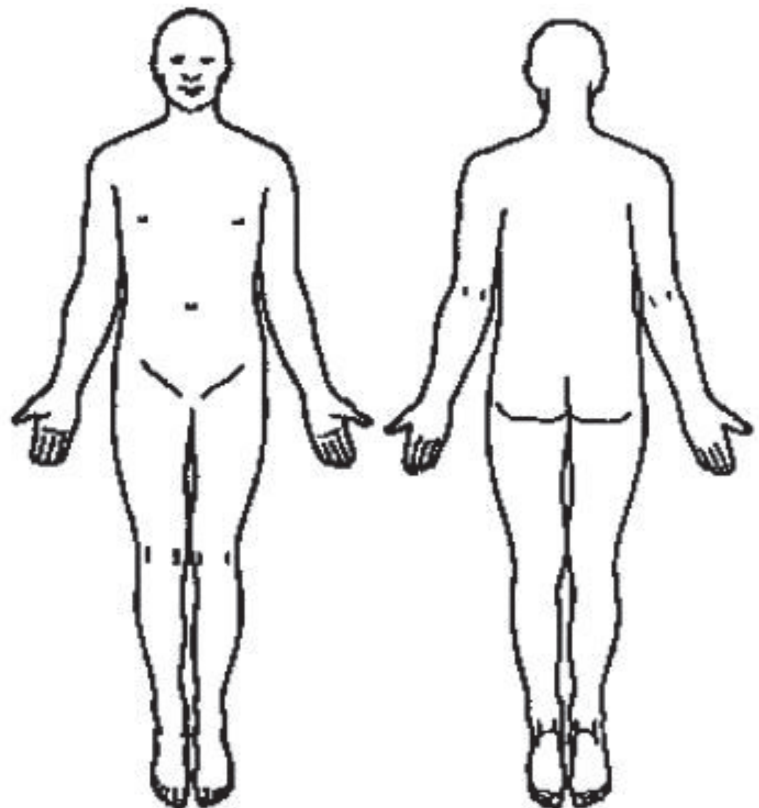
Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:

Use the Following Colors:

Pain= Blue

Numbness/Tingling= Yellow

Stiffness= Green



Name:____ Date:______________

Past Medical History, Family Medical History, and Medications

L>1.B Communication Forms>Communication forms>A&M>A&M New Pt. intake & mrkt intake

Previous surgeries:

What surgery?________________________________ When?________________

What surgery?________________________________ When?________________

What surgery?________________________________ When?________________

What surgery?________________________________ When?________________

What surgery?________________________________ When?________________

Any other disease/conditions:

____

____

Medications:

____

____

____

____

____

Have you ever had a stroke? ☐ Yes ☐ No If yes, when? ________________

Has anyone in your family had a stroke? ☐ Yes ☐ No If yes, who?________________

Family Medical History: Please list any further disease/conditions in your family below

Father:____

Mother:____

Siblings:____

Children:____

I have no knowledge of my family history ☐

Patient Signature____________________________________Date:______________

Dr's Initials:____________ Date:______________

Name: ____ Date: __________________________

Review of Systems

Please circle and list any symptoms that apply to you. If no symptoms apply, circle "negative."

Eyes	Negative	Vision Change / Glasses / Contacts / Glaucoma	Comments:
Ear, Nose, and Throat	Negative	Ulcers/ Sinusitis / Headache / Hearing Loss	Comments:
Cardiovascular	Negative	Chest Pain / Edema / Palpitations / Blood Thinners / Difficulty Breathing on Exertion / High Blood pressure / CHF / Stroke / A-Fib Heart Condition / PACE Maker / Electrical Implant / High cholesterol	Comments:
Respiratory	Negative	Wheezing / Coughing Blood / COPD / TB Pneumonia / Shortness of Breath / Cough Bronchitis	Comments:
Gastrointestinal	Negative	Diarrhea / Bloody Stool / Nausea Vomiting / Indigestion / Constipation / Gall bladder / Liver / Pancreas / Stomach reflux / GERD	Comments:
Genitourinary	Negative	Bladder Urgency/Frequency / Blood in Urine Painful Urination / Incontinence / Incomplete Emptying / Painful Intercourse / Abnormal/Painful Periods / Abnormal Vaginal Bleeding / Abnormal Vaginal Discharge Kidney Disease / Bladder Inflection / Gout / Hernia Hemorrhoids	Comments:
Hormonal Imbalance	Negative	Low Libido / Hot flashes / PMS / Vaginal Dryness / Bleeding Problems / Fatigue	Comments:
Musculoskeletal	Negative	Joint pain / Muscle pain / Muscle Weakness Neck Pain / Back Pain / Plantar Fasc. / Tailbone Pain / Arthritis / Hand Tingling / Feet Numbness / Feet Burning	Comments:
Skin	Negative	Rash / Ulcers / Fibrome / Dry Skin / Pigmented Lesions / Hives / Eczema / Easily bruises Swelling	Comments:
Breast	Negative	Mastalgia / Discharge / Masses / Lymphedema Mastectomy / Cancer	Comments:
Neurologic	Negative	Fainting / Seizures / Numbness / Severe Memory Loss Difficulty Walking / Tremors / Twitches / Epilepsy / Migraines / Insomnia	Comments:
Psychiatric	Negative	Crying / Bipolar / Mood Disorder / Depression / Anxiety / Stress	Comments:
Endocrine	Negative	Diabetes / Hypothyroid / Hair Loss / Heat-Cold Intolerance / Thyroid issues / Hyperthyroidism	Comments:
Hematologic/Lymphatic	Negative	Bleeding / Swollen Lymph Nodes Anemia / Hepatitis / Thrombophlebitis Deep Vein Thrombosis / Blood Clots Varicose Veins	Comments:
Other	Negative	Aids/HIV / Shingles / Herpes Simplex Lupus / Cancer / Fibromyalgia / Stroke Implantable Device / PACE Maker / Insulin pump / Insulin monitor implant / A-fib implant	Comments:

Which of the following is **true** for your condition: (check one of the following)?		
____ It's getting better on its own	____ It's staying the same	____ It's getting worse as time goes by

List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited:

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.

Signature ____ Date _________________________

WHO REFERRED YOU TO 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: < NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

Knee Pain Program Qualification Questionnaire

(Please answer ALL the following questions by circling one answer per question.)

Thank you for completing this questionnaire. Please return to the front desk.

1. Do you experience knee pain? Right / Left / Both
2. Do you experience knee pain at rest? Yes / No
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? Yes / No / Unsure
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months? Yes / No
5. Do you have morning knee stiffness lasting 30 minutes or less? Yes / No
6. Do you experience a grinding sensation with knee movement? Yes / No
7. 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
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? Yes / No
9. 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

A&M Regenerative Therapy Patient 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.

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

- ☐ Medications
- ☐ Emergency Room
- ☐ Nutrition/Diet
- ☐ Vitamins
- ☐ ______________________________
- ☐ Routine Medical
- ☐ Exercise
- ☐ Holistic Care
- ☐ Chiropractic
- ☐ ______________________________

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

- ☐ Bad results
- ☐ Same Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did not get worse
- ☐ Did not work very long
- ☐ Still Trying
- ☐ Confused

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

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

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

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

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Need surgery
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Amputation/losing toes or limb

1. List the 3 most important reasons why you want help, without using the word "pain":

A. ______________________________

B. ______________________________

C. ______________________________

A&M Regenerative Therapy Patient Quality of Life Survey

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

3. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples & explain how they are affected.
   A.
   B.
   C.

4. What frustrates or concerns you most due to your current limitations or condition?

5. Where do you picture yourself in the next 1-3 years if this problem is not taken care of?

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

7. What do you desire most to get from working with us?

8. What would that mean to you?

Name ____________________________ Date________________

Date ___________________ **Name: ___________________________**

A&M Wellness Centre

Do you have a Pace Maker Y N Electrical Implant Y N Brain Shunt Y N

Which of the following is true for your condition: (check one of the following)?

__It's getting better on its own __Its staying the same __ it's getting worse as time goes by

List any daytime activities (you used to be able to do when you were feeling better) that are now limited:

____

____

____

____

What Frustrates or Concerns you about any of the above limitations:_______________________________________

____

____

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.

C. I Request and consent to treatment, including various modes of physical therapy and diagnostic x-rays that maybe performed by the doctor or trained assistants. I understand that treatment may be performed by the doctors of chiropractic of A&M Chiropractic and/or Care Wellness Center or other licensed doctors working at this clinic.

Who referred you to our office?____

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

Patient signature: ____ Date: __________

Witness Signature: ____ Date: __________

____

***Please wear or bring a short sleeve shirt & shorts for your exam.**