

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

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

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| PLEASE LIST BELOW ANY BACK, KNEE, OR LEG SURGERIES YOU'VE HAD? | |
| | |
| HAVE YOU HAD AN EMG PERFORMED ON YOUR LEGS/FEET? <input type="checkbox"/> NO <input type="checkbox"/> YES - WHEN: | |
| DO YOU EXERCISE REGULARLY? <input type="checkbox"/> NO <input type="checkbox"/> YES - WHAT: | |
| ARE YOUR SYMPTOMS WORSE AT NIGHT ? <input type="checkbox"/> NO <input type="checkbox"/> 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 |
|------|-------|---------------|--------|---------|----------|----------|

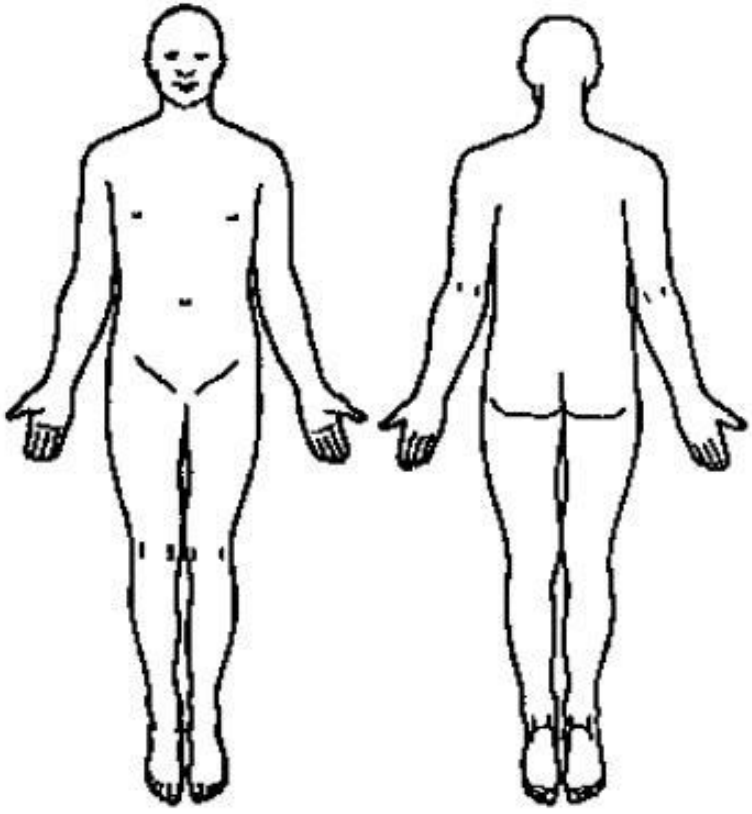
How would you describe your average knee pain over the past week?
 No pain Worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

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



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 worst as time goes by

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

List the three main "health goals" that you would like to accomplish:

1)

2)

3)

- 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 _____

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: < 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