# 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 #: _____

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

How did you hear about our office? _____

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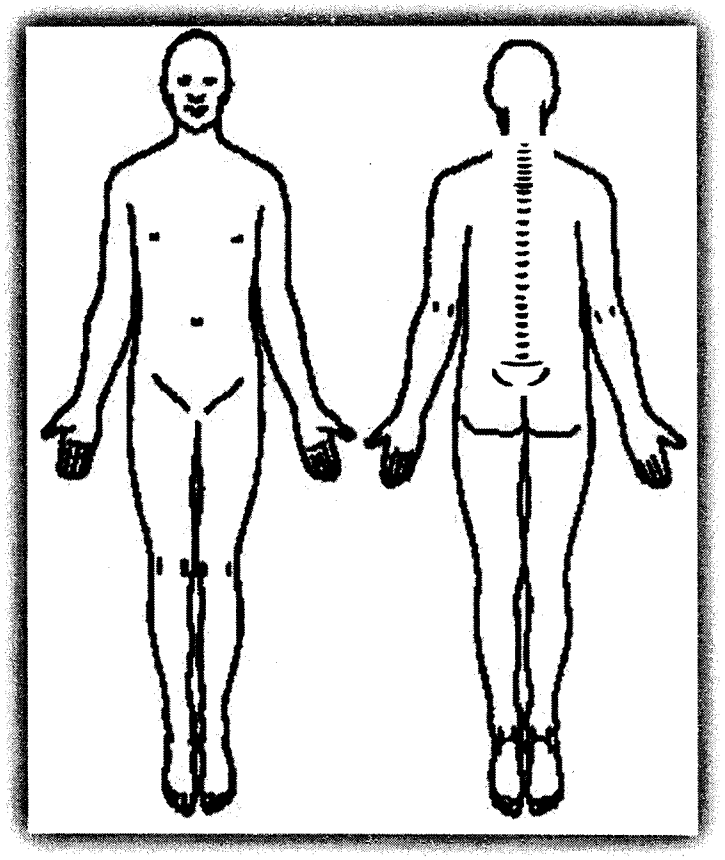
**Please indicate on this drawing the area(s) where you are currently experiencing symptoms:**



**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.

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Signature: _____ Date: _____

## 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?** _____

_____

# Knee Function Questionnaire

These questions ask about limitations you may be experiencing due to your knee pain during the last 10 days. For each question, please circle only ONE answer that best describes your degree of limitation.

| **In the past 10 days, how has your knee pain affected....** | **Not Affected/ Able to Complete** | **A Little/ Affected but Still Able to Complete** | **Quite a Bit/ Unable to Complete Some Days** | **Moderately/ Unable to Complete Most Days** | **Extremely/ Unable to Complete Task** |
|---|---|---|---|---|---|
| Your ability to walk without assistance (cane or walker) ? | 1 | 2 | 3 | 4 | 5 |
| Your ability to walk without a limp? | 1 | 2 | 3 | 4 | 5 |
| The distance you are able to walk? | 1 | 2 | 3 | 4 | 5 |
| Your ability to use stairs (up or down)? | 1 | 2 | 3 | 4 | 5 |
| Your ability to fall asleep or stay asleep through the night | 1 | 2 | 3 | 4 | 5 |
| Your balance or stability when walking or standing? (Falling, Unsure of footing) | 1 | 2 | 3 | 4 | 5 |
| Your ability to get up from a seated position? | 1 | 2 | 3 | 4 | 5 |
| Your ability to complete daily activities around your home? (laundry, dishes, cooking, etc.) | 1 | 2 | 3 | 4 | 5 |
| Your ability to complete errands? (grocery shopping, doctors appts, etc.) | 1 | 2 | 3 | 4 | 5 |
| Your ability to get in and out of a vehicle? | 1 | 2 | 3 | 4 | 5 |