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	☐ 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

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? ☐ YES ☐ NO	
PLEASE LIST BELOW ANY **BACK, KNEE, OR LEG SURGERIES** YOU'VE HAD?	
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

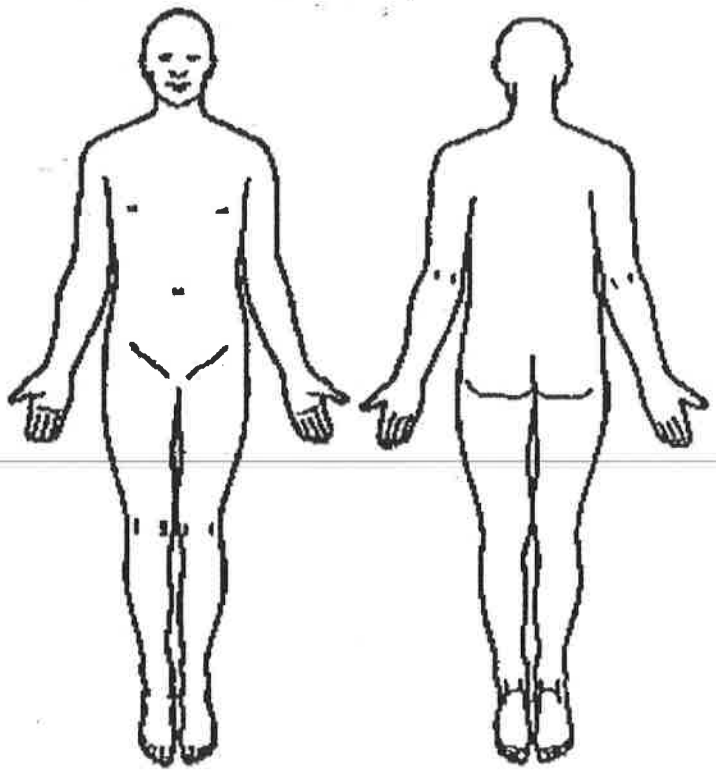
Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:

Use the Following Colors:

Pain= Blue

Numbness/Tingling= Yellow

Stiffness= Green



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?

_____

LYSHOLM KNEE SCORING SCALE

Instructions: Below are common complaints which people frequently have with their knee problems. Please check the statement which best describes your condition.

I. LIMP:

____ I have no limp when I walk. (5)
____ I have a slight or periodical limp when I walk. (3)
____ I have a severe and constant limp when I walk. (0)

II. USING CANE OR CRUTCHES

____ I do not use a cane or crutches. (5)
____ I use a cane or crutches with some weight-bearing. (2)
____ Putting weight on my hurt leg is impossible. (0)

III. LOCKING SENSATION IN THE KNEE

____ I have no locking and no catching sensations in my knee. (15)
____ I have catching sensation but no locking sensation in my knee. (10)
____ My knee locks occasionally. (6)
____ My knee locks frequently. (2)
____ My knee feels locked at this moment. (0)

IV. GIVING WAY SENSATION FROM THE KNEE

____ My knee never gives way. (25)
____ My knee rarely gives way, only during athletics or other vigorous activities. (20)
____ My knee frequently gives way during athletics or other vigorous activities, in turn I am unable to participate in these activities. (15)
____ My knee occasionally gives way during daily activities. (10)
____ My knee often gives way during daily activities. (5)
____ My knee gives way every step I take. (0)

V. PAIN:

____ I have no pain in my knee. (25)
____ I have intermittent or slight pain in my knee during vigorous activities. (20)
____ I have marked pain in my knee during vigorous activities. (15)
____ I have marked pain in my knee during or after walking more than 1 mile. (10)
____ I have marked pain in my knee during or after walking less than 1 mile. (5)
____ I have constant pain in my knee. (0)

VI. SWELLING

____ I have no swelling in my knee. (10)
____ I have swelling in my knee only after vigorous activities. (6)
____ I have swelling in my knee after ordinary activities. (2)
____ I have swelling constantly in my knee. (0)

VII. CLIMBING STAIRS:

____ I have no problems climbing stairs. (10)
____ I have slight problems climbing stairs. (6)
____ I can climb stairs only one at a time. (2)
____ Climbing stairs is impossible for me. (0)

VIII. SQUATTING

____ I have no problems squatting. (5)
____ I have slight problems squatting. (4)
____ I can not squat beyond a 90 degree bend in my knee. (2)
____ Squatting is impossible because of my knee. (0)

TOTAL____/100

INSTRUCTIONS: Please place an X on the line to indicate the amount of pain you have had in your knee(s) the past 24 hours. The scale ranges from "no pain at all" to the "worst possible pain".

RIGHT KNEE _____

no pain worst possible pain

LEFT KNEE _____

no pain worst possible pain