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

Marital Status: S M D W **Spouse's Name:** _____ **Spouse's DOB:** _____

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 Feeling | ☐ 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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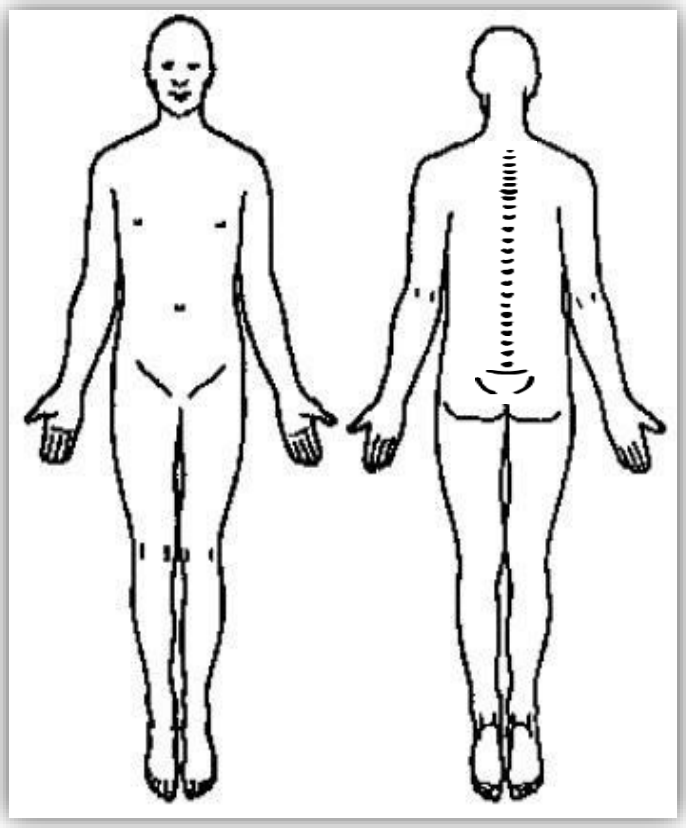

Please indicate on this drawing the area(s) where you are currently experiencing symptoms:

Comments:

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	☐ Mid Back Pain	☐ Neck Pain	☐ Shingles
☐ Sciatica	☐ Vascular Surgery(s)	☐ Stroke	☐ Kidney Disease
☐ Leg or Foot Pain/Numbness	☐ Joint Replacement	☐ High Blood Pressure	☐ Dialysis
☐ Vascular Leg Problems	☐ Heart Attack	☐ 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 for your knee pain:

Name	Dosage per Day

Name of your Primary Care Physician: _____ Clinic: _____

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

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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? _____

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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

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Financial Policy: It is our firm belief that all our patients deserve quality care. For us to provide this level of service, it is important that our patients understand our financial policies.

If we are participating providers in your plan, we will accept assignment for payment and submit a claim on your behalf to the insurance company. You must provide our office with accurate insurance information for us to file your claim. Failure to provide accurate information may forfeit your right for us to file your claim. Some insurance companies require you to satisfy an office copay and/or deductible before they submit payment. We require copays and/or deductibles be paid at the time services are rendered. It is important to remember that your insurance coverage is a contract between you and your insurance company. You are responsible for any balances or charges not covered by your insurance.

If you receive a patient statement, please remember you have already received services from our office and the balance is your responsibility. If you are unable to pay your balance in full, please contact our billing department to make payment arrangements.

We accept cash, check and credit cards. Which payment will you be using? Cash ☐ Check ☐ Credit Card ☐

Assignment and Instruction for Direct Payment to Doctor: I hereby direct and instruct my insurance company to pay Discover Specific Chiropractic. A photocopy of this assignment shall be considered as effective and valid as the original. | understand | am financially responsible for any amount not covered by my insurance policy. | also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. This form is my signature on file.

Medicare Patients Only: Medicare will only pay for service that it determines to be "reasonable and necessary" under Section 1962(a) (1) of the Medicare law. If Medicare determined that a particular service, although it would otherwise be covered, is "not medically necessary" under Medicare program standards, Medicare will deny payment for that service. (X-rays and Examination) | have been notified by my physician that he/she believes that Medicare is likely to deny payment for my X-rays and Examination and | agree to be personally responsible for payment of the agreed services.

Privacy Policy: We are very concerned with protecting your privacy. We may disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health. We have more than one doctor in our office and your information may be shared with other doctors. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any request, such as these, must be made in writing. However, we are not required to agree to you restrictions.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, we will leave a voice mail. Our office sends out new patient letters, post cards, birthday cards and statements periodically.

By signing this, I hereby acknowledge that have read and understand Discover Specific Chiropractic's privacy policy. I understand that I may obtain a copy of the privacy notice.

_____ _____

Signature of Responsible Party Date

_____ _____

Witness Date

Would you like to receive texts regarding appointments/questions? Please circle one. ☐ Yes ☐ No