Community Chiropractic
Knee Pain Application

Legal Name _____ Preferred Name _____

Birth Date _____/_____/_____ Age _____ Height _____ Weight _____

Address _____ Cell Phone _____

_____

Email Address _____

Marital Status S M D W Spouse Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Are there any other family members/friends who are involved in your health/financial decisions?

If so: Name/Contact Information _____

Occupation (Current or Previous) _____ Retired? Y N

How did you hear about our office? TV Facebook Seminar Mailer Other _____

What is the main health concern you are coming in for today? _____

When did your symptoms begin? _____

Is there anything that makes them worse? _____

Is there anything that makes them better? _____

Is this condition interfering with any of the following areas? (circle all that apply)

Work Sleep Daily Routine Chores Lifting Exercise Shopping Other: _____

How would you describe your symptoms? (circle all that apply)

Stabbing/Sharp Electric Shocks Cold Tingling Pins + Needles Dead Feeling Throbbing

Burning Stinging Achy Numb Swelling Fatigue Cramping Grinding Limping Weak

Frequency of your symptoms

___ Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (25% or less)

On average, at what level would you rate your overall knee pain?

NONE 1 2 3 4 5 6 7 8 9 WORST POSSIBLE PAIN

How serious and committed are you about taking care of this concern/condition?

NOT SERIOUS 1 2 3 4 5 6 7 8 9 TOTALLY COMMITTED

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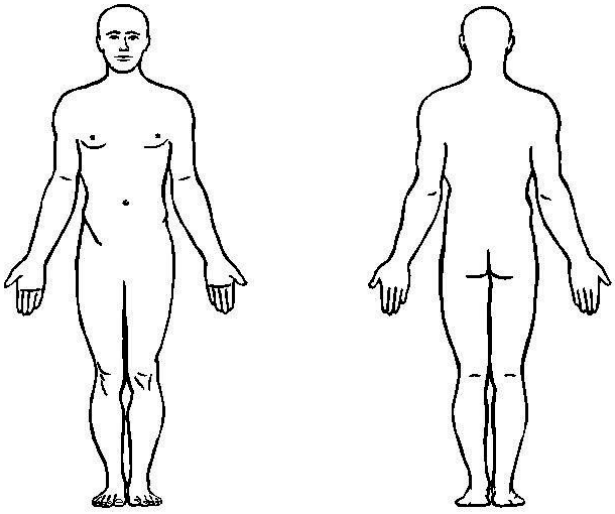
Please indicate on the drawings the body area(s) where you are currently experiencing symptoms

Which knee is bothering you?

___ Left

___ Right

___ Both



Has your condition interfered with daily activities (walking, going up/down stairs, prolonged standing, transitioning from sitting to standing) for at least six (6) months? _____

Have you tried pain and/or anti-inflammatory medications for at least 3 months without gaining long-term relief from your symptoms (Tylenol, Aleve, Meloxicam, Capsaicin Cream, Hemp/CBD Cream, etc.)? _____

Have you attempted physical therapy to the affected knee, or participated in a personal exercise program without long-term relief from your symptoms? _____

Have you used a knee brace without long-term relief of your symptoms? _____

If yes, what type of knee brace? _____

Have you had an MRI performed on your legs, knees, or feet? **N Y**

If yes, when? _____

Have you tried steroid or cortisone injection(s) without long-term relief? **N Y** How many? _____

Has your doctor ever drained excess fluid from the affected knee(s)? _____

Have you had any other surgical procedure done to your legs, knees, or feet? **N Y**

If yes, please list the procedures and approximate dates _____

_____

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Comprehensive Health History

Primary Care Physician Name _____

Clinic Name / Phone Number _____

Do we have your permission to send them records of your visits here if they request us to? **Y N**

Please list any serious medical conditions you have had (diagnosed conditions, etc.) _____

_____

Circle **Y**es or **N**o for each condition listed below:

Y N Lower Back Pain	**Y N** Diabetes (Last A1C = _____)	**Y N** Herniated Disc
Y N Leg or Foot Pain/Numbness	**Y N** Neuropathy	**Y N** Sciatica
Y N Spinal Surgery	**Y N** High Cholesterol	**Y N** Spinal Stenosis / Arthritis
Y N Knee Surgery	**Y N** Heart Attack	**Y N** Neck Pain
Y N Vascular Leg Problems	**Y N** Heart Problems	**Y N** Gout
Y N Vascular Surgery	**Y N** Stroke	**Y N** Shingles
Y N Leg Fractures	**Y N** Kidney Issues	**Y N** Joint Replacement
Y N Foot Surgery	**Y N** Dialysis	**Y N** Hand Problems

Please list any medications and/or vitamins you are currently taking (or attach a list to this form)

_____ _____

_____ _____

_____ _____

Are you currently taking a **blood thinner?** (Coumadin, Lovenox, Heparin, etc.) **Y N**

Are you currently taking a **statin?** (Atorvastatin, Lipitor, Crestor, Simvastatin, etc.) **Y N**

Do you have an **electrical implant** of any kind? (spinal stimulator, bladder stimulator, etc.) **Y N**

Alcohol Use: __ Never __ Rarely __ Moderately __ Daily # _____ __ Former User

Tobacco Use: __ Never __ Rarely __ Moderately __ Daily # _____ __ Former User

Other Drug Use: __ Never __ Rarely __ Moderately __ Daily # _____ __ Former User

Do you Exercise regularly? **Y N** If yes, how long and how often? _____

What type of exercise? _____

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Functional Goals Survey

Please take several minutes to answer these questions so we can best serve you.

How many doctors have you seen for this condition? _____

What recommendations did they give you (medications, supplements, therapies, treatments, etc.)?

_____
_____
_____

Have the things you have done so far for this condition helped?

Yes, a lot Yes, some No, not at all I'm not sure

List some activities you can no longer do, or are struggling with because of this condition. Please be specific.

_____ _____
_____ _____
_____ _____

If this problem continues to progress, what do you envision your life will be like? Please be specific.

_____
_____

What would be different if this problem was gone? Please be specific.

_____
_____

In order for the treatments in our office to be considered successful to you, what would need to happen? What are the results you would like to see?

_____
_____

In the last 10 days my knee pain has affected…

1. My ability to walk without assistance 1 2 3 4 5
2. My ability to walk without a limp 1 2 3 4 5
3. The distance I am able to walk 1 2 3 4 5
4. My ability to go up or down stairs 1 2 3 4 5
5. My ability to fall asleep or stay asleep 1 2 3 4 5
6. My balance or stability when walking or standing 1 2 3 4 5
7. My ability to get up from a seated position 1 2 3 4 5
8. My ability to complete daily activities around my home (laundry, dishes, etc.) 1 2 3 4 5
9. My ability to complete errands around town (groceries, appointments, etc.) 1 2 3 4 5
10. My ability to get in and out of a vehicle 1 2 3 4 5

1 = Not Affected, able to complete easily

2 = Slightly Affected, still able to complete

3 = Affected, unable to complete sometimes

4 = Moderately Affected, unable to complete most days

5 = Extremely Affected, never able to complete