

# 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 #: \_\_\_\_\_

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 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?

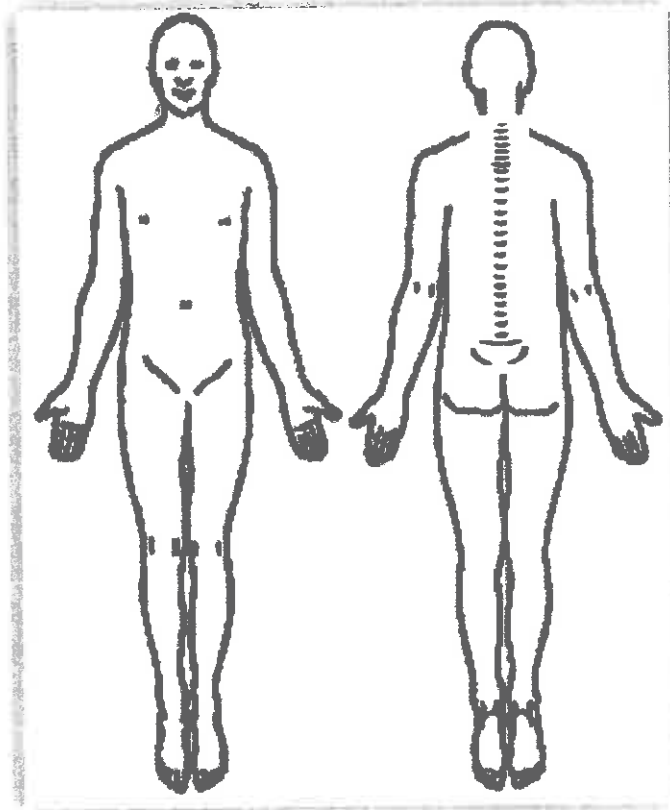
No Pain      1      2      3      4      5      6      7      8      9      10      Worst Pain Possible

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 dally activitles (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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Low Back Pain             | <input type="checkbox"/> Vascular Leg Problems | <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Shingles       |
| <input type="checkbox"/> Sciatica                  | <input type="checkbox"/> Vascular Surgery(s)   | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Leg or Foot Pain/Numbness | <input type="checkbox"/> Joint Replacement     | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Dialysis       |
| <input type="checkbox"/> Neck Pain                 | <input type="checkbox"/> Knee Surgery(s)       | <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Gout           |
| <input type="checkbox"/> Hand Pain/Numbness        | <input type="checkbox"/> Leg Fracture          | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Herniated/Bulging Disc    | <input type="checkbox"/> Foot Surgery(s)       | <input type="checkbox"/> Neuropathy                 |   |
| <input type="checkbox"/> Spinal Arthritis          | <input type="checkbox"/> Spinal Surgery(s)     | <input type="checkbox"/> 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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

# KNEE PAIN APPLICATION

## 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?

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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? \_\_\_\_\_

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What would be different &/or better in your life without this problem? *Please be specific.*

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What is your biggest fear if this condition continues to progress? \_\_\_\_\_

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What would success mean to you in our office? \_\_\_\_\_

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Print Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Informed Consent for Medical / Chiropractic/ Acupuncture/NAET/ Decompression/ Laser Treatment

Dear Patient,

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about your condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you better informed in order that you can knowingly give or withhold your consent.

Every type of health care is associated with some risk of a potential problem. This includes Medical/Chiropractic/ Decompression Laser Therapy /Acupuncture/NAET care. We want you to be informed about potential problems associated with Medical /Chiropractic/ Decompression/ Laser /Acupuncture/NAET care before consenting to treatment. This is called informed consent.

### Chiropractic:

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function ( primarily the nervous system) and this relationship can affect the restoration and preservation of health.

Chiropractic adjustments/ joint mobilizations are performed by Chiropractors. It is the moving of bones to correct or reduce spinal and extremity joint subluxations with the doctor's hands or with the use of a mechanical device, following palpation and/or other examination procedures. A Vertebral Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and /or does not move properly causing interference and /or irritation to the nervous system. The primary goal of Chiropractic Care is the removal and/or reduction of the nerve interference caused by vertebral subluxation. A Chiropractic examination will be performed which may include spinal and physical examination , orthopedic and neurological testing, palpation, specialized instrumentation, x-rays and laboratory testing. Frequently with spinal or joint adjustments techniques create a "pop" or "click" sound/sensation in the area being treated, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. In addition some ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy, paraffin wax, cervical traction, mechanical traction, therapeutic exercises, vibrational –proprioceptive rehab, spinal and knee decompression, acupuncture/acupressure, laser, laser acupuncture may also be used. In this office, we use trained staff personal to assist the doctor(s) with portions of your consultation, examination, x-ray taking, physical therapy application, traction, decompression, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor under the direction of the primary doctor will treat you on that day.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment.

**Disc Herniation:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments/joint mobilizations, traction, decompression etc. This includes both in the neck and in the back. Yet, occasionally chiropractic treatment (adjustments/joint mobilizations, traction, spinal decompression/knee decompression etc.) may aggravate the problem and rarely surgery may become necessary for correction.

Rarely chiropractic adjustment/joint mobilizations may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments/joint mobilizations, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no statistics to quantify their probability.

**Rib Fractures:** The ribs are found only in the thoracic spine or the middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment/joint mobilization will crack a rib bone, and this is referred to as a fracture.

Informed Consent for Medical / Chiropractic/ Acupuncture/NAET/Decompression/ Laser Treatment  
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Print Patient Name: \_\_\_\_\_

This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust/manipulate all patients very carefully, and especially those who have osteoporosis noted on their x-rays. These problems occur so rarely that there are no statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, laser therapy ( class 3 cold laser ). We can recommend ice or heat or moist heat therapy for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no statistics to quantify their probability. Furthermore physiotherapy may include the proceeding as well as a allergic reaction to gels or lotions in some cases.

Soreness: It is common for chiropractic adjustments/joint mobilizations, traction, massage therapy, exercise, etc. to result in a temporary increase in the soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please tell your doctor about it.

Acupuncture: If using dry needling technique the following risks can occur: infection at site of insertion of needle, bruising, itching, redness, swelling, allergic response to needle.

NAET: Sweating when holding the substance, itching, fatigue after treatment, muscle weakness after treatment.

Probability of risks occurring: There may be other problems or complications that might arise from Chiropractic/Medical/Acupuncture/NAET other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and / or explain them all in advance of treatment. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult. The same consequences can occur with patients suffering from allergies, chronic conditions and specific medical problems not listed here.

Chiropractic/ Medical/ Acupuncture/ NAET is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease, or condition as a result of treatment in this center. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

1. I, \_\_\_\_\_, authorize the performance upon myself of the following procedure(s): Examination/ X-rays( gowned if needed) Ultrasound, sinusoidal current, interferential currents, traction, decompression, hydrocollator, electrical muscle stimulation, laser therapy , ice therapy, acupuncture, N.A.E.T, and chiropractic manipulative/joint mobilization techniques to be performed by or under the direction of the Doctors and staff of Integrated Medical Center, Inc. d.b.a./Quantum Medical & Wellness Center
2. I also consent to the performance of other diagnostic and / or therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the doctors, associates and / or assistants, may consider necessary or advisable in the course of my health care or treatment.

3. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the doctors, their associates or assistants.
4. I have read the explanation above of medical / chiropractic/ acupuncture / NAET/decompression treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I, \_\_\_\_\_ of my own free will choose to become a patient of Drs./Therapists Popkin/Grundstein/Desir/Debrosse. I understand that some of the techniques and products used in this clinic are neither FDA (Food and Drug Association) approved or considered a "main stream" traditional medicine.

Drs. Popkin/Grundstein//Desir/Debrosse can not guarantee the results of these treatments or products.

I am aware that I am free to seek other medical opinions or other care at any time. I am also aware that Drs. Popkin/Grundstein/ Desir/ Debrosse meet the requirements by Florida law.

I hereby exercise my freedom of choice in Medicine/Chiropractic/ NAET/Acupuncture/ Decompression Therapy/ Massage Therapy/ Manual Therapy/ Laser Therapy to follow Drs. Popkin/Grundstein/Desir/Debrosse recommendations or not as I choose.

Signed \_\_\_\_\_ Date \_\_\_\_\_



➔ **PRACTICE INFORMATION HERE**  
**Patient Quality Of Life Survey**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please take several minutes to answer these questions so we can help you get better.  
(Please circle as many that apply)

1 How have you taken care of your health in the past?

- a. Medications
- b. Emergency Room
- c. Routine Medical
- d. Exercise
- e. Nutrition/Diet
- f. Holistic Care
- g. Vitamins
- h. Chiropractic
- i. Other (please specify): \_\_\_\_\_

2 How did the previous method(s) work out for you?

- a. Bad results
- b. Some results
- c. Great results
- d. Nothing changed
- e. Did not get worse
- f. Did not work very long
- g. Still trying
- h. Confused

3 How have others been affected by your health condition?

- a. No one is affected
- b. Haven't noticed any problem
- c. They tell me to do something
- d. People avoid me

4 What are you afraid this might be (or beginning) to affect (or will affect)?

- a. Job
- b. Kids
- c. Future ability
- d. Marriage
- e. Self-esteem
- f. Sleep
- g. Time
- h. Finances
- i. Freedom

5 Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

➔ How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

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➔ What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

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➔ What are you most concerned with regarding your problem?

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➔ Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

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➔ What would be different/better without this problem? Please be specific

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➔ What do you desire most to get from working with us?

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➔ What would that mean to you?

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## Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

### Let's get started.

Please circle any that apply to you prior to taking the quiz below:

#### Sub-Clinical symptoms including:

Headaches and migraines

#### Hormone imbalance including:

PMS

Emotional imbalance

#### Gastrointestinal issues including:

Abdominal bloating and cramps or painful gas

Irritable Bowel Syndrome

Ulcerative Colitis

Crohn's Disease and other intestinal disorders

#### Respiratory Conditions including:

Chronic sinusitis

Asthma

Allergies

#### Autoimmune Conditions including:

Diabetes Mellitus

Lupus

Rheumatoid Arthritis

Fibromyalgia

Chronic Fatigue

#### Developmental and social concerns including:

Austism

ADD/ADHD

#### Skin Conditions: (urticaria)

Eczema

Skin rashes

Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

### TYG Wellness Questionnaire

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3	Asthma, hayfever, or airborne allergies	0	1	2	3
Abdominal pain or bloating	0	1	2	3	Confusion, poor memory or mood swings	0	1	2	3
Mucous or blood in stool	0	1	2	3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3	History of antibiotic use	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3	Alcohol consumption makes you feel sick	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3	Ulcerative colitis or celiac's disease	0	1	2	3
Sinus or nasal congestion	0	1	2	3	Nausea	0	1	2	3
Chronic or frequent inflammations	0	1	2	3	Weight Trouble	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3					

YOUR TOTAL: \_\_\_\_\_