

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ Social Security# _____ Date _____

Date of Birth _____ Age _____ Sex M F Marital Status M S D W # of children _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Spouse's Name _____ Phone Number _____

Your Occupation _____ 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 _____ Phone Number _____

TELL US ABOUT YOUR PAST HEALTH:

➔ Please check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Diabetes (A1C = _____) | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Leg or Foot Pain /Numbness | <input type="checkbox"/> Hand Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Spinal Fractures | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Knee Surgery |
| <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney issues or Dialysis |
| <input type="checkbox"/> Spinal Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hip Surgery |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Vascular Leg Problems | <input type="checkbox"/> Leg Fractures |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Vascular Surgery _____ | <input type="checkbox"/> Joint Replacement |
| | <input type="checkbox"/> Stroke | <input type="checkbox"/> Foot Surgery |

PLEASE LIST ANY MEDICATION AND/OR VITAMINS YOU ARE CURRENTLY TAKING OR ATTACH MED LIST:

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

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? Yes No WHEN? _____
 DO YOU EXERCISE REGULARLY? Yes No WHAT? _____
 ARE YOUR SYMPTOMS **WORSE AT NIGHT**? Yes No 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?

- Stabbing-Sharp
 Electric-Shocks
 Cold
 Tingling
 Swelling
 Burning
 Stings
 Ache
 Numbness
 Tiredness
 Cramping

→ IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING:

- Sleep
 Work
 Daily Routine
 Chores
 Walking
 Standing
 Shopping

CURRENT PAIN LEVELS

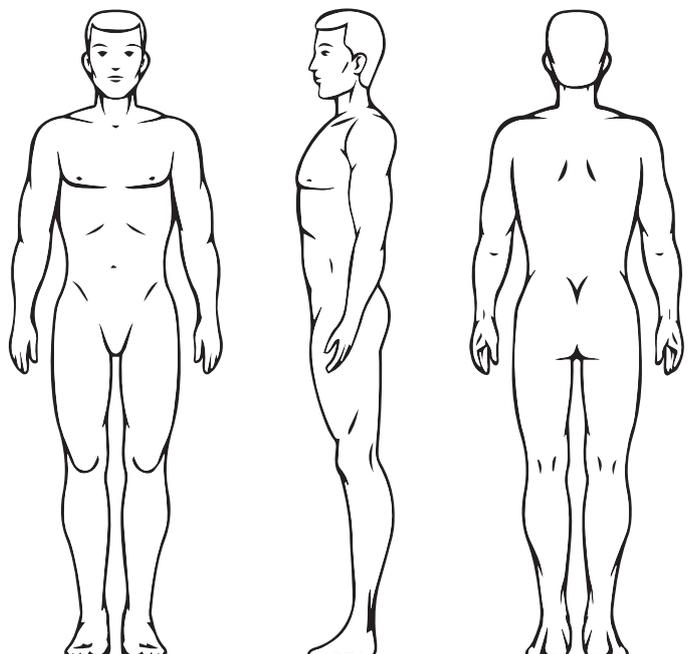
→ How would you describe your average knee pain over the past week?

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

→ 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 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

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



➔ WHICH OF THE FOLLOWING IS TRUE FOR YOUR CONDITION:

- It's getting better on its own It's staying the same It's getting worse 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. _____

STATEMENT

- 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?

→ WALKING SCALE QUESTIONNAIRE

These questions ask about limitations to your walking due to knee pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

IN THE PAST 2 WEEKS, HOW MUCH HAS YOUR KNEE PAIN...	NOT AT ALL	A LITTLE	MODERATELY	QUITE A BIT	EXTREMELY
LIMITED YOUR ABILITY TO WALK?	1	2	3	4	5
LIMITED YOUR ABILITY TO RUN?	1	2	3	4	5
LIMITED YOUR ABILITY TO CLIMB UP OR DOWN STAIRS?	1	2	3	4	5
MADE STANDING WHEN DOING THINGS MORE DIFFICULT?	1	2	3	4	5
LIMITED YOUR BALANCE WHEN STANDING OR WALKING?	1	2	3	4	5
LIMITED HOW FAR YOU ARE ABLE TO WALK?	1	2	3	4	5
INCREASED THE EFFORT NEEDED FOR YOU TO WALK?	1	2	3	4	5
MADE IT NECESSARY FOR YOU TO USE SUPPORT WHEN WALKING INDOORS (E.G. HOLDING ON TO FURNITURE, USING A CANE, ETC.)?	1	2	3	4	5
MADE IT NECESSARY FOR YOU TO USE SUPPORT WHEN WALKING OUTDOORS (E.G. USING A CANE OR WALKER, ETC.)?	1	2	3	4	5
SLOWED DOWN YOUR WALKING?	1	2	3	4	5
AFFECTED HOW SMOOTHLY YOU WALK?	1	2	3	4	5
MADE YOU CONCENTRATE ON YOUR WALKING?	1	2	3	4	5

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

WALKING SCALE DISABILITY SCORE: < 13 NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

BLUEPRINT TO HEALTHCARE/WEIGHT LOSS/NEUROPATHY/KNEE PAIN

➔ KNEE PAIN PROGRAM QUALIFICATION QUESTIONNAIRE
(PLEASE ANSWER ALL THE FOLLOWING QUESTIONS BY CIRCLING ONE ANSWER PER QUESTION)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN TO THE FRONT DESK.

1. Do you experience knee pain? Right Left Both
2. Do you experience knee pain at rest? Yes No
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? Yes No Unsure
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months? Yes No
5. Do you have morning knee stiffness lasting 30 minutes or less? Yes No
6. Do you experience a grinding sensation with knee movement? Yes No
7. Have you tried pain and/or anti-inflammatory medications (i.e.: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief? Yes No
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? Yes No
9. Have you attempted to lose weight to help with your knee pain? Yes No
10. Have you used a knee brace without long-term relief? Yes No
11. Has your doctor ever drained excess fluid from the affected knee(s)? Yes No
12. Have you tried steroid/cortisone injection(s) to the knee without long-term relief? Yes No