Application for Knee Pain Treatment (Please Print Clearly)

blueprint to Knee Pain

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

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

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

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

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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?

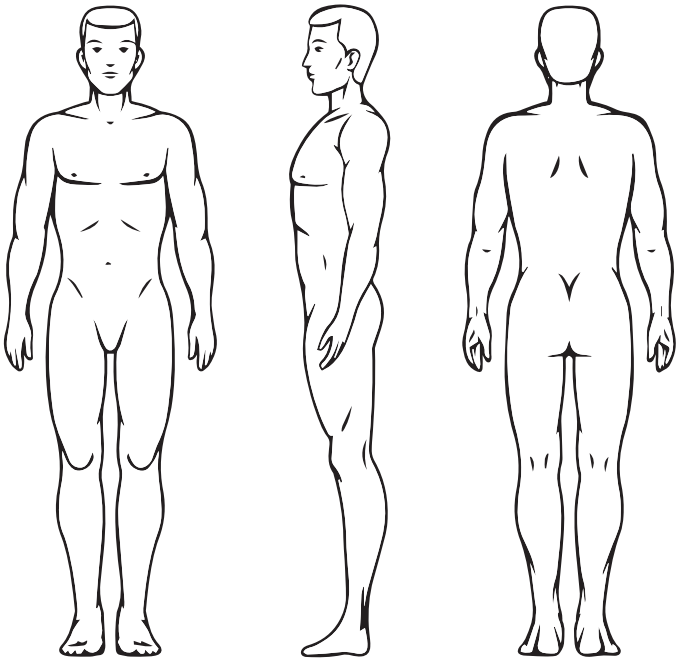
NO PAIN **1 2 3 4 5 6 7 8 9 10** WORST PAIN POSSIBLE

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:

Use the Following Colors:
Pain= Blue
Numbness/Tingling= Yellow
Stiffness= Green



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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

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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 ☐

Patient Quality Of Life Survey Example

blueprint to Contour

PIVOTAL HEALTH

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:

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

What are you most concerned with regarding your problem?

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

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

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

What would that mean to you?

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
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____