KNEE PAIN APPLICATION

Name: _____ (Last Name / First Name / Middle Initial) Date: ___/___/___ (MM DD YYYY)

Nickname: _____ Date of Birth: ___/___/___ (MM DD YYYY) 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 #: _____

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

How did you hear about our office? _____

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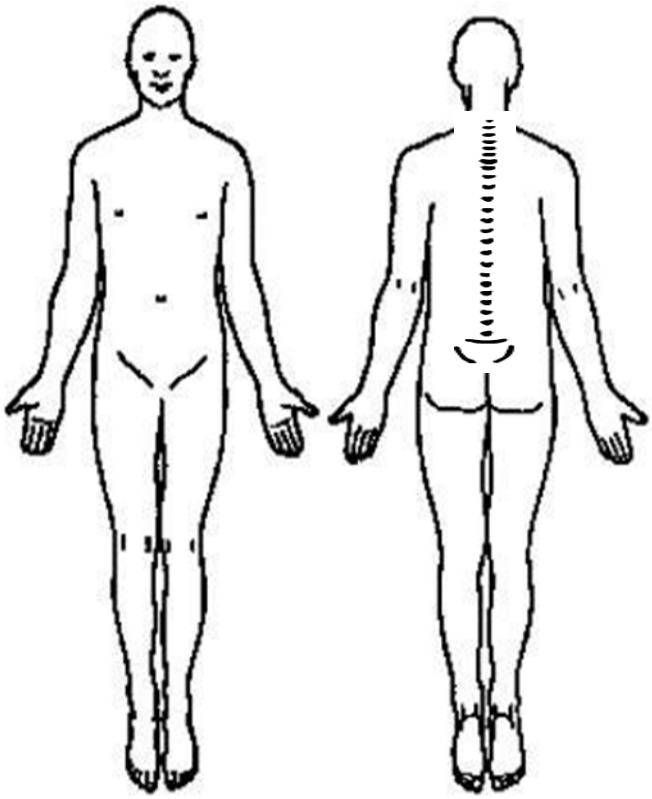
Please indicate on this drawing the area(s) where you are currently experiencing symptoms:

Please use pencil tool/drawing tool or circle tool to circle areas of discomfort. (Or when you are done, print this document and circle spots with a pen)



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	☐ Vascular Leg Problems	☐ Heart Attack	☐ Shingles
☐ Sciatica	☐ Vascular Surgery(s)	☐ Stroke	☐ Kidney Disease
☐ Leg or Foot Pain/Numbness	☐ Joint Replacement	☐ High Blood Pressure	☐ Dialysis
☐ Neck Pain	☐ Knee Surgery(s)	☐ High Cholesterol	☐ Gout
☐ Hand Pain/Numbness	☐ Leg Fracture	☐ Cancer	☐ Pacemaker/Defib
☐ Herniated/Bulging Disc	☐ Foot Surgery(s)	☐ Neuropathy	☐ Blood Thinners
☐ Spinal Arthritis	☐ Spinal Surgery(s)	☐ Diabetes (last A1c=_____)	☐ Other:_____

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 Accelerated Chiropractic.
- I understand that Accelerated Chiropractic cannot file the knee treatments to insurance at this time.
- Accelerated Chiropractic 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: ___/___/_____
MM DD YYYY

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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? _____

_____

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

Accelerated Chiropractic
& Natural Healing Center, LLC

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CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Hamling and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Hamling and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To the best of my knowledge I am ***NOT*** pregnant and Dr. Hamling has my permission to x-ray me for diagnostic interpretation.

By signing this authorization, I am also agreeing to have text and/or email sent to the number or email I have provided, from Accelerated Chiropractic and its employees.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctors recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

X _____ / / _____
Patient's Signature or person acting on patient's behalf MM DD YYYY **Date**

X _____ / / _____
Witness Signature MM DD YYYY **Date**