Date____/___/_____ Patient Name_____

A & M Wellness Centre

Application for Knee Pain Treatment (Please Print Clearly)

NAME:			SOCIAL SECURITY #:	MARITAL STATUS: M S D W
				#OF CHILDREN:
DATE OF BIRTH:	AGE:	SEX: F M	RETIRED: Y N	SPOUSE'S NAME:
ADDRESS:				
CITY:			STATE:	ZIP:
HOME PHONE #:			CELL PHONE #:	
E-MAIL ADDRESS:			OCCUPATION (CURRENT OR PREVIOUS):	
TYPE OF WORK (CURRENT OR PREVIOUS), Clerical:Y / N Light Labor:Y / N / Moderate Labor:Y / N / Heavy Labor: Y / N				

TELL US ABOUT YOUR PAST HEALTH:

Y	N	Lower Back Pain	Y	N	Diabetes (A1C = _____)	Y	N	High Cholesterol
Y	N	Leg or Foot Pain/Numbness	Y	N	Hand Problems	Y	N	Shingles
Y	N	Prior Spinal Surgeries	Y	N	Neuropathy	Y	N	Knee Surgery
Y	N	Spinal Fractures	Y	N	Heart Attack	Y	N	Kidney issues or Dialysis
Y	N	Spinal Stenosis	Y	N	Heart Problems	Y	N	Gout
Y	N	Spinal Arthritis	Y	N	High / Low Blood Pressure	Y	N	Hip Surgery
Y	N	Sciatica	Y	N	Vascular Leg Problems	Y	N	Leg Fractures
Y	N	Neck Pain	Y	N	Vascular Surgery _____	Y	N	Joint Replacement
Y	N	Herniated Disc	Y	N	Stroke	Y	N	Foot Surgery
Do you have any of the following electronic implants?								
Y	N	Pace Maker	Y	N	Insulin Pump	Y	N	Other:

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

If you need more space, please check here and continue on back.

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:

NAME OF YOUR PRIMARY CARE PHYSICIAN:

MAY WE CONTACT THEM WITH UPDATES REGUARDING YOUR TREATMENT? ❑YES ❑NO

PLEASE LIST BELOW ANY BACK, LEG, OR KNEE SURGERIES YOU'VE HAD?

HAVE YOU HAD AN EMG PERFORMED ON YOUR LEGS/FEET? ❑YES ❑NO WHEN?

DO YOU EXERCISE REGULARLY? ❑YES ❑ NO WHAT TYPE?

ARE YOUR SYMPTOMS WORSE AT NIGHT? ❑YES ❑NO AROUND WHAT TIME?

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WHAT KIND OF PROBLEMS ARE YOU HAVING?

ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS THIS WEEK? (10 IS THE WORST, 0 IS NO PAIN AT ALL)										
0	1	2	3	4	5	6	7	8	9	10
WHEN DID THIS BEGIN:										
WHAT MAKES IT BETTER:										
WHAT MAKES IT WORSE:										

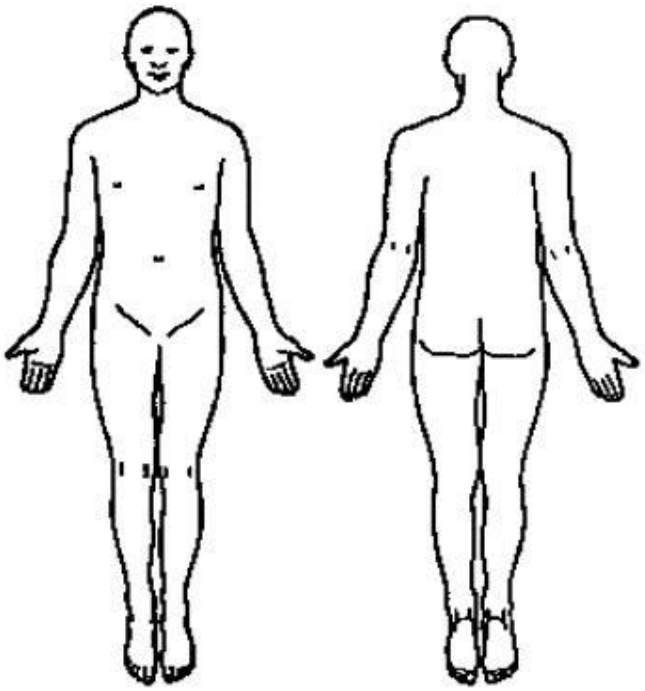
HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (CIRCLE ALL THAT APPLY)	STABBING-SHARP	ELECTRIC SHOCKS	COLD	TINGLING	PINS + NEEDLES	DEAD FEELING	THROBBING
	BURNING	STINGS	ACHE	NUMBNESS	SWELLING	TIREDNESS	CRAMPING

WHAT DO YOU THINK IS CAUSING YOUR PROBLEM:										
IS THIS CONDITION INTERFEREING WITH ANY OF THE FOLLOWING: (CIRCLE ALL THAT APPLY)										
WORK	SLEEP	DAILY ROUTINE	CHORES	WALKING	STANDING	SHOPPING				
HOW WOULD YOU DESCRIBE YOUR AVERAGE KNEE PAIN OVER THE PAST WEEK: NO PAIN WPRST POSSIBLE PAIN										
0	1	2	3	4	5	6	7	8	9	10
PLEASE INDICATE WHAT YOU CONCIDER TO BE AN ACCEPTABLE LEVEL OF PAIN AFTER COMPLETIONG OF THE TREATMENT, IF YOU HAVE TO ACCEPT SOME PAIN: (0 IS NO PAIN AND 10 IS WORST PAIN POSSIBLE_										
0	1	2	3	4	5	6	7	8	9	10

Please indicate, on these drawings, the body areas where you are currently experiencing symptoms:

Use these indicators:

- ★ = **Pain**
- ○ = **Numbness/Tingling**
- □ = **Stiffness**



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WHICH OF THE FOLLOWING ID TRUE FOR YOUR CONDITION: (CHECK ONE OF THE FOLLOWING)?		
____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 FELLING BETTER) THAT ARE NOW LIMITED:		
LIST THE THREE MAIN "HEALTH GOALS" THAT YOU WOULD LIKE TO ACCOMPLISH:		
1)		
2)		
3)		
Authorization and Consent to Treatment		
A. I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECCESSARY 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.		
C. I REQUEST AND CONSENT TO CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING VARIOUS MODES OF PHYSICAL THERAPY AND DIAGNOSTIC X-RAYS. I UNDERSTAND THAT THE CHIROPRACTIC TREATMENT MAY BE PERFORMED BY THE DOCTORS OF CHIROPRACTIC OF A&M CHIROPRACTIC AND/OR CARE WELLNESS CENTER OR OTHER LICENSED DOCTORS OF CHIROPRACTIC. THERAPY MODALITIES, DIRECTED BY THE DOCTOR OF CHIROPRACTIC, MAY BE PERFORMED BY THE DOCTOR'S STAFF WORKING AT THIS CLINIC OR OFFICE. CHIROPRACTIC TREATMENT MAY ALSO BE PERFORMED BY A DOCTOR OF CHIROPRACTIC WHO IS SERVING AS A BACKUP FOR THE DOCTOR OF CHIROPRACTIC. I HAVE HAD THE OPPORTUNITY TO DISCUSS WITH THE DOCTOR OF CHIROPRACTIC NAMED BELOW, MY DIAGNOSIS, THE NATURE AND PURPOSE OF MY CHIROPRACTIC TREATMENT, THE RISKS AND BENEFITS OF ALTERNATIVE TREATMENT, INCLUDING NO TREATMENT AT ALL.		
WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGUARDING 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 YO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR INSURANCE STATUS.		
Patient Signature:		Date:
Witness Signature:		Date:
EMERGENCY CONTACT: Who should we contact in case of an emergency?		
Name:	Phone #	Relationship to patient:
Name:	Phone #	Relationship to patient:
WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT OUT OFFICE?		

Date____/___/_____ Patient Name_____

A & M Wellness Centre

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: < 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)

1. Do you experience knee pain? ❑Right ❑Left ❑Both
2. Do you experience knee pain at rest? ❑Yes ❑No
3. Do you have knee osteoarthritus 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-inflamatory medications (i.e.: Tylenol, Aspirin, Advil, or capsacian 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 perosnal ecerside 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

Thank you for completing this questionnaire. Please return the form to the front desk.

Review of Systems

Please circle and list any symptoms that apply to you

Eyes	Negative	Vision Change Glasses/Contacts Glaucoma	Comments:
Ear, Nose, and Throat	Negative	Ulcers Sinusitis Headache Hearing Loss	Comments:
Cardiovascular	Negative	Chest Pain Edema Palpation Blood Thinners Difficulty Breathing on Exertion HBP CHF Stroke A-Fib	Comments:
Respiratory	Negative	Wheezing Coughing Blood COPD TB Pneumonia Shortness of Breath Cough Bronchitis	Comments:
Gastrointestinal	Negative	Diarrhea Bloody Stool Nausea/Vomiting/Indigestion Constipation	Comments:
Genitourinary	Negative	Bladder Urgency/Frequency Blood in Urine Painful Urination Incontinence Incomplete Emptying Painful Intercourse Abnormal/ Painful Periods Abnormal Vaginal Bleeding Abnormal Vaginal Discharge Kidney Disease Bladder Inflection Gout Hernia Hemorrhoids	Comments:
Hormonal Imbalance	Negative	Anxiety Migraines Low Libido Memory Hot flashes PMS Stress Insomnia Mood Swings Depression Joint Pain Muscle Pain Vaginal Dryness Bleeding Problems Thyroid Issues Fatigue	Comments:
Musculoskeletal	Negative	Muscle Weakness Fibrome Neck Pain Back Pain Plantar Fasc Tailbone Pain Arthritis Hand Tingle Feet Numb Burning Feet	Comments:
Skin	Negative	Rash Ulcers Dry Skin Pigmented Lesions Hives Eczema	Comments:
Breast	Negative	Mastalgia Discharge Masses	Comments:
Neurologic	Negative	Fainting Seizures Numbness Severe Memory Loss Difficulty Walking Tremors Twitches Epilepsy	Comments:
Psychiatric	Negative	Crying Bipolar Mood Disorder	Comments:
Endocrine	Negative	Diabetes Hypothyroid Hair Loss Heat/Cold Intolerance	Comments:
Hematologic/Lymphatic	Negative	Bruises Bleeding Swollen Lymph Nodes Anemia Hepatitis Thrombophlebitis Deep Vein Thrombosis	Comments:
Other	Negative	Aids/HIV Shingles Herpes Simplex Lupus Cancer Fibromyalgia Stroke Implantable Device	Comments: