Family Chiropractic Clinic
Optimal Health Nutrition Center

Chiropractic and Nutritional Treatments
Dr. Mark A. Pederson
Chiropractor & Clinical Nutritionist
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Knee Intake Form:

Title: __Dr. __Miss __Mr. __Mrs. __Ms.
First: _____
Middle Initial: ____
Last: _____
Preferred Name: _____
Sex: __Male __Female
Date of Birth: _____

Street: _____
City: _____
State: _____
Zip: _____
Social Security #: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____ Cell Phone Carrier: _____
Does your plan include text messaging? __ Yes __No
Does your plan include email messaging? __ Yes __No

***PLEASE NOTE**: In order to better serve you we utilize text messaging to remind you of your scheduled appointment.*

Email: _____
***PLEASE NOTE**: In order to better serve you we utilize email messaging to remind you of your scheduled appointment.*

Emergency contact information:

Name: _____
Relationship: _____
Phone 1: _____
Phone 2: _____
Marital Status: __Single __Married __Widowed __Separated __Divorced
Spouse Name: _____
Spouse Occupation: _____
Spouse Employer: _____
Employment:
Your employment status:
__Employed __Employed Part-time __Retired __Part-time student __Full-time student

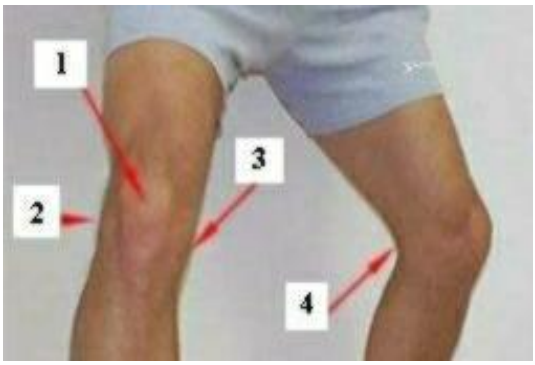
Employer: _____
Employer:

- Address: _____
- City: _____
- State: _____
- Zip: _____
- Phone #: _____

Occupation: _____
Type of Work: __Office/Clerical __Light labor __Moderate labor __Heavy labor

Insurance Company: _____

Where does your knee hurt? Please check all areas that apply.



Area Number 1: In the front of the knee
_____I have no pain here
_____I have some pain here
_____Most of my pain is here

Area Number 2: On the outside of my knee
_____I have no pain here
_____I have some pain here
_____Most of my pain is here

Area Number 3: On the inside of my knee:
_____I have no pain here
_____I have some pain here
_____Most of my pain is here

Area Number 4: In the back of my knee:
_____I have no pain here
_____I have some pain here
_____Most of my pain is here

Do you have active cancer? Yes /No
Do you have a pacemaker? Yes /No

My pain is (circle all that apply): Sharp / Dull / Stabbing / Aching / Burning Constant / Intermittent / Quick to come and go / Awakens me from my sleep.

My pain is present with (circle all that apply): Activity / Rest / Both.

My pain is aggravated by (circle all that apply): Walking uphill or stairs / Walking downhill or stairs / Twisting / Kneeling / Getting up out of a chair / Getting out of bed in the morning Running / Jumping / Bending my knee / Straightening my knee.

My pain radiates (spreads or travels): Yes / No If yes, where does it go?_____

Is your knee swollen when you wake up in the morning? Yes / No

Mechanical symptoms:

- Does your knee catch, lock or feel like it is getting stuck? Yes / No
- Does your knee give out or buckle without warning? Yes / No
- Do you feel grinding within your knee? Yes / No
- Do you feel unusually cold below your knee into your leg and foot? Yes / No
- Do you notice swelling into your lower leg and foot? Yes / No

Have you ever had surgery on your knee(s)? If yes, please explain.

_____

Please circle which tests you have had for your knee problem: X-Rays / CAT Scans / MRI / Bone Scans / Ultrasound

Do you take NSAID medications for this problem (ibuprofen/Advil, Naproxen, Aleve, Celebrex, etc.): Yes / No

Have you taken narcotic pain pills for this problem (Vicoden, Percocet, etc.): Yes / No

Have you had cortisone shots for this problem: Yes/No

- If yes please estimate how many and when _____

Have you been to physical therapy for this problem?Yes / No

- If yes please estimate how many sessions _____

Are you currently doing exercises on your own for this problem? Yes / No

Do you wear a brace or wrap on your knee or inserts in your shoes for this problem? Yes / No

- If yes briefly describe

_____

Comments:

Is there anything that I have not asked above that you think is important for me to know?

_____

_____

Knee Function: On each question, circle yourself on a scale of 1 to 5.

1. Your overall level of pain:
    1= Slight pain and/or no trouble
    2= Slight pain and/or little trouble
    3= Moderate pain and/or moderate trouble
    4= Serious pain and/or extreme difficulty
    5= Severe pain and/or impossible

2. Pain and difficulty bathing and drying yourself:
    1= Slight pain and/or no trouble
    2= Slight pain and/or little trouble
    3= Moderate pain and/or moderate trouble
    4= Serious pain and/or extreme difficulty
    5= Severe pain and/or impossible

3. Pain and difficulty getting in and out of a car, operating the vehicle, or using public transportation:
    1= Slight pain and/or no trouble
    2= Slight pain and/or little trouble
    3= Moderate pain and/or moderate trouble
    4= Serious pain and/or extreme difficulty
    5= Severe pain and/or impossible

4. Indicate the length of time you're able to walk before experiencing severe knee pain (with or without a cane):
    1= >30 min
    2= 16-30 minutes
    3= 5-15 minutes
    4= Less than five minutes
    5= Can't walk without severe pain

5. After sitting in a chair or at a table and then getting up to stand, what level of pain do you experience?
    1= Slight pain and/or no trouble
    2= Slight pain and/or little trouble
    3= Moderate pain and/or moderate trouble
    4= Serious pain and/or extreme difficulty
    5= Severe pain and/or impossible

6. Do you limp because of your knee and, if so, what is the severity of the limp?
    1= Not at all
    2= Sometimes or only at first
    3= Often
    4= Most of the time
    5= Constantly

7. Are you able to kneel down and get back up easily afterwards?
    1= Yes, without any problem
    2= Yes, with slight difficulty
    3= Yes, with moderate difficulty
    4= Yes, with extreme difficulty
    5= Not possible

8. Does the knee pain interfere with sleep?
    1= Never
    2= Once in a while
    3= Some nights
    4= Most nights
    5= Every night

9. Are you able to work and/or do housework?
    1= Not at all
    2= Occasionally
    3= Fairly often
    4= Most of the time
    5= All the time

10. Does your knee ever feel as though it's going to give way?
    1= Not at all
    2= Occasionally
    3= Fairly often
    4= Most of the time
    5= All the time

11. Are you able to do household shopping?
    1= Yes, with minimal or no problem
    2= Yes, most of the time
    3= Yes, fairly often
    4= Sometimes
    5= Rarely or never

12. Are you able to walk down a flight of stairs?
    1= Yes, with minimal or no problem
    2= Yes, most of the time
    3= Yes, fairly often
    4= Sometimes
    5= Rarely or never

Total Score = _____

Results

54 or higher: Indicates that your condition is fairly severe.
43 to 53: Indicates a moderate problem.
30 to 42: Indicates some problem or inhibited function.
18 to 29: Indicates that your condition is relatively mild.
18 or lower: Indicates that you have little to no knee problems.

Family Chiropractic
Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is call a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Doctor's Signature

Minors:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Females:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature	Date

Revised 11/2016