The Knee Clinic Intake Form

Welcome to the Knee Clinic! We are a private fee-for-service clinic. Please complete the following questionnaire. Your answers will help determine the level of care we are able to provide to you. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate healthcare provider in a timely manner.

PERSONAL INFORMATION Date ______________________

Name: ________________________ / _________________________ / ____________ ____________________________

Last Name First Name Middle Initial Preferred Name

Birth Date: _________ /_______ /_______ Healthcare #: ____________________ Province: ❑ AB ❑ Other: _____________

YYYY MM DD

Gender: ___________________ Marital Status: ____________________ Height: ________ Weight: ________

Current Occupation: ____

Home Address: ____ City: ______________________ Postal Code: ______________

Phone #s: Home _________________________ Cell _________________________ Work _________________________

Do you consent to receiving emails regarding health information, reminders, and important clinic updates?
❑ Yes, I consent to receiving email communication from the clinic.

Email Address: ____

Emergency Contact: ____

Name Relationship Phone Number

Family Doctor (G.P.): ____

Name Location Phone Number

Please be advised that in the interest of inter-professional communication, we will be in touch with your physician regarding the care you receive at our clinic.

Were you referred by your family doctor? ❑ Yes ❑ No

If you were not referred by your doctor, how did you hear about us?
❑ Google ❑ Facebook ❑ GO Adventure Guide ❑ Online News/Newspaper ❑ TV ❑ Radio ❑ Referred by: _________________

Is this a workplace injury? ❑ Yes; please be advised that we do not accept WCB cases. ❑ No

Is your injury the result of a motor vehicle accident? ❑ Yes; additional intake forms are required. ❑ No

Our healthcare team meets regularly to discuss interdisciplinary care for the purpose of improved patient care.
Do you consent to details of your case being discussed among our healthcare team? ❑ Yes ❑ No Please initial here:

Our clinic is committed to evidence-based practice and contributing to the scientific research community. All patient information used in research is kept strictly confidential and is used only with permission of the patient.
Do you consent to allow your information to be used in future research? ❑ Yes ❑ No Please initial here:

Re-examinations:
Re-examinations are done at no extra cost in the event of a six-month time lapse between office visits.

Missed Office Visits:
As a courtesy, we ask that our patients give at least 24 hours' notice when cancelling or rescheduling appointments. A Missed Office Visit Fee of $65 may be charged to your account in the event of a missed appointment/late cancellation, with the fee increasing to $85 in the event of 3 separate missed appointments/late cancellations. Please initial here: ______

CURRENT COMPLAINT – This information will be particularly useful during your Knee Clinic Initial Appointment

1. In your own words, please describe your chief complaint and when you first noticed the problem.

____

____

2. Is this a new problem, or is it a recurring issue?

   ❑ This is a new problem.

   ❑ This is a recurring issue. How frequently does it occur? ______________________________________

3. Have you had any previous treatment to your knee?

   ❑ Yes. Please list: ____

   ❑ No.

4. What seems to make the problem worse? ____

5. What seems to make the problem better? ____

6. What type of pain is it? (Please check) ❑ Sharp ❑ Stabbing ❑ Achy ❑ Burning ❑ Dull ❑ Other: ___________

7. At what time of day does your pain seem to be at its worst? _______________________________________

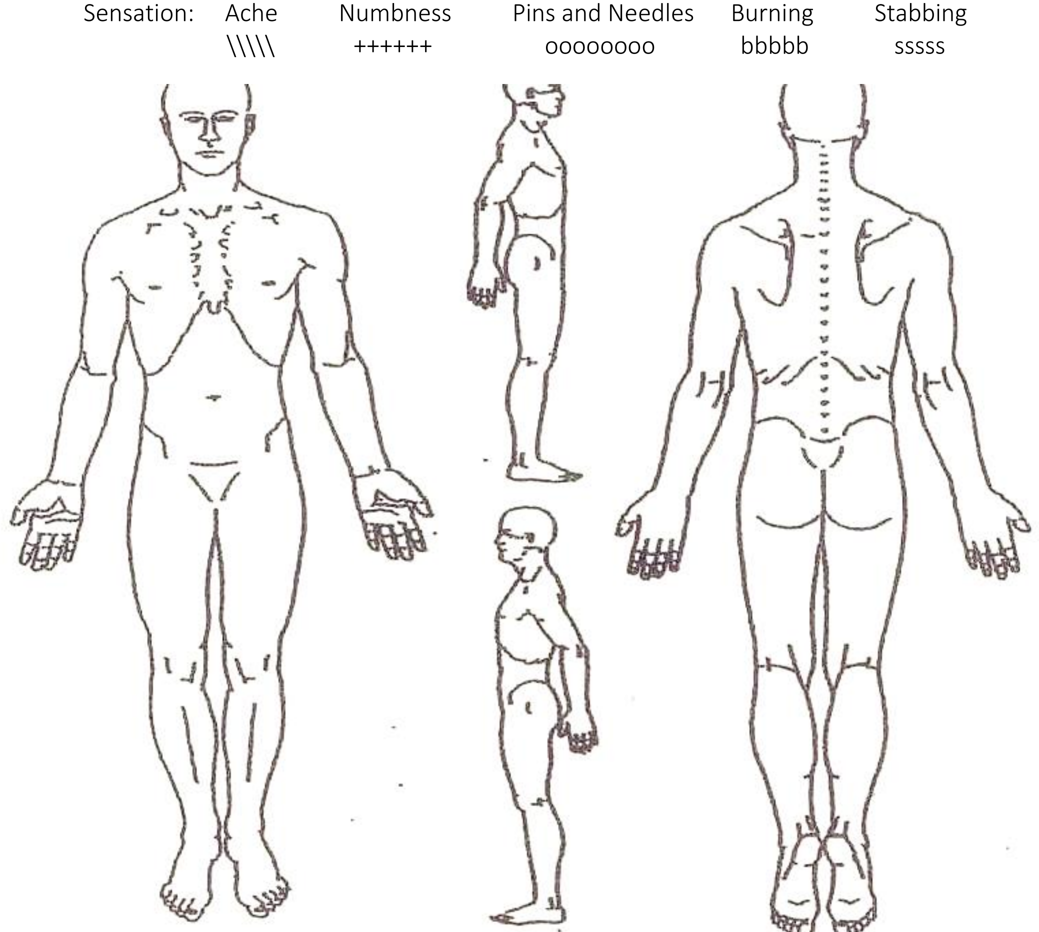
8. Does your knee: (Please check) ❑ Lock ❑ Give out on you ❑ Make cracking noises

9. Using the line scale provided below, rate the pain you are experiencing <u>now</u>:

   <u>No pain</u> 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 <u>Severe Pain</u>

10. Mark the areas on the body drawings below where you feel the following sensations using their corresponding symbols. Include all affected areas.

Sensation:	Ache	Numbness	Pins and Needles	Burning	Stabbing
	\\\\\	++++++	oooooooo	bbbbb	sssss



Consent to Chiropractic Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:
● **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
● **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
● **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
● **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
● **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed. CCPA 09.15 Page 2 of 2
● **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.
Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment.

I hereby consent to chiropractic treatment as proposed to me.

____
Name (Please Print)

_____________________________________ Date________________ 20____
Signature of patient (or legal guardian)

_____________________________________ Date________________ 20____
Signature of Chiropractor

HEALTH INFORMATION – This information will be particularly useful during your Inflammatory consultation with one of our NDs

1. How would you rate your general health?

   Poor 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Excellent

2. What are your health goals?

   ____

3. Medical conditions and health concerns.
   Please list all diagnosed medical conditions (current and past) and any other health concerns.

   ____

   ____

   To what extent do these concerns interfere with your daily activities (work, sleep, etc.)?

   Not at all 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Interfere greatly

4. Allergies: (list all known food, drug, and environmental allergies)

   ____

   ____

5. Medications: (list all prescription & over the counter)

Name	Dosage	For what	For how long

6. Supplements/Vitamins/Herbals: (list all herbal, nutritional & nutraceutical products)

Name	Dosage	For what	For how long

7. Recent infections and antibiotic use (last 5 years):

   ____

   ____

8. Dental:

   Dentist Name: ____
   Location Phone Number

   Please list all dental work, treatments, infections, surgery, or appliances (excluding regular cleaning):

   ____

   ____

9. Lifestyle

Energy level: Zero 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Lots!

Does your energy level vary throughout the day? ❑ Yes ❑ No

When do you feel at your best (B) or your worst (W) throughout a day?

Midnight - 4am 5am - 8am 9am - Noon 1pm - 4pm 5pm - 8pm 9pm - Midnight

Sleep quality: Very poor 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Great!

How many hours of sleep do you get per night? ____ hours

Stress Level: Zero 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Lots!

What are your main stressors? (work, personal, relationship, health, school, etc.)

____

____

Do you smoke? ❑ No. ❑ Yes. For how many years? ______ How many per day? ______
❑ In the past. When did you quit? _________________

Physical activity: ❑ Regular exercise/activity ❑ Some exercise/activity ❑ Sedentary lifestyle ❑ I am immobile

What exercise/activity do you participate in (including times/week, duration and how long you have been doing it)?

____

____

Diet: Please describe your typical meals and food below.

Breakfast ____ Time eaten: _______

Lunch ____ Time eaten: _______

Dinner ____ Time eaten: _______

Snacks ____ Time eaten: _______

Are you a vegetarian? ❑ Yes; what kind? (Lacto Ovo Lacto-ovo Pesco Vegan) ❑ No

Are there any foods or drinks that you find hard to digest or that aggravate your symptoms?

____

Beverages: How many glasses/servings do you have of the following per day?

Coffee:____ Black tea:____ Green/herbal tea:____ Juice:____ Pop:____ Milk:____ Alcohol:____ Water:____

What type of water do you drink? ❑ Tap ❑ Spring ❑ Purified

Attire/Hygiene

Your first visit to the office includes an initial consultation and an examination for us to best determine how we can help. At the discretion of the doctor, your first visit may not consist of actual treatment.
Some treatments necessitate direct skin contact. Please bring shorts to each appointment and bathe before attending your appointment.
Please refrain from wearing any cologne, perfumes, or scented lotions while in the clinic.

HEALTH STATUS SURVEY

Present Symptoms: Please check ☑ the box for any **current** symptoms or conditions.
Past Symptoms: Please cross ☒ the box for any **past** symptoms or conditions.

GENERAL SYMPTOMS
- ❑ Headache
- ❑ Concussion
- ❑ Blackouts
- ❑ Loss of consciousness
- ❑ Convulsions
- ❑ Fever
- ❑ Excess sweating
- ❑ Night sweats
- ❑ Night pain
- ❑ Unexplained weight gain/loss
- ❑ Fatigue
- ❑ Poor sleep
- ❑ Generalized pain

MUSCLES AND JOINTS
- ❑ Jaw pain
- ❑ Sore/Stiff neck
- ❑ Low back pain
- ❑ Mid back pain
- ❑ Painful tailbone
- ❑ Shoulder pain
- ❑ Arm/forearm pain
- ❑ Elbow pain
- ❑ Wrist/hand pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Ankle/foot pain
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Loss of strength
- ❑ Muscle twitches

SKIN RELATED
- ❑ Eczema
- ❑ Dermatitis
- ❑ Recent changes in moles
- ❑ Bruise easily
- ❑ Dry skin/hair/nails
- ❑ Oily skin/hair/nails
- ❑ Acne
- ❑ Rashes/itching
- ❑ Boils
- ❑ Hives (allergies)

NEUROLOGIC
- ❑ Dizziness
- ❑ Fainting
- ❑ Numbness or tingling
- ❑ Lack of coordination
- ❑ Problem speaking
- ❑ Problem swallowing
- ❑ Blurred vision
- ❑ Double vision
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression

CARDIOVASCULAR
- ❑ Bleeding disorder
- ❑ High/low blood pressure
- ❑ Chest pain
- ❑ Stroke
- ❑ Hardening of arteries
- ❑ Varicose veins
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Angina
- ❑ Heart disease
- ❑ Blood clots

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Indigestion
- ❑ Nausea
- ❑ Heartburn
- ❑ Excess hunger/thirst
- ❑ Bloating
- ❑ Vomiting
- ❑ Pain over stomach
- ❑ Pain with bowl movement
- ❑ Constipation
- ❑ Black/bloody stools
- ❑ Hemorrhoids
- ❑ Gall bladder issues
- ❑ Liver issues
- ❑ Ulcer
- ❑ Diarrhea
- ❑ Diabetes

RESPIRATORY
- ❑ Asthma
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Spitting up phlegm/blood
- ❑ Bronchitis
- ❑ Pneumonia

EYES/EARS/NOSE/THROAT
- ❑ Cataracts
- ❑ Eye pain
- ❑ Failing vision
- ❑ Earache/ear discharge
- ❑ Failing hearing
- ❑ Ring/buzz in ears
- ❑ Nose bleeds
- ❑ Frequent colds
- ❑ Sinus infection
- ❑ Thyroid issues
- ❑ Enlarged glands
- ❑ Bleeding gums

GENITOURINARY
- ❑ Trouble urinating
- ❑ Incontinence
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Blood in urine
- ❑ Sores on genitals
- ❑ Prostate trouble
- ❑ Hot flashes
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Irregular/absent cycle
- ❑ Cramping
- ❑ Backache
- ❑ Vaginal discharge
- ❑ Swollen breasts
- ❑ Lump in breasts

Are you currently on birth control?
❑ Yes ❑ No

Are you currently pregnant?
❑ Yes ❑ No

DECLARATION AND INFORMED CONSENT TO TREATMENT

This form is designed to present benefits and risks of the therapies offered by Dr. Eric Arrata, ND and Dr. Rahim Moledina, ND and must be signed before treatment is rendered. Ask your naturopathic doctor if you have any questions or concerns regarding your consent to treat prior to signing this Declaration and Informed Consent to Treatment form.

Treatments may include one or a combination of the following:

- Dietary and nutritional counselling
- Nutritional and other supplementations, either orally, topically or as injection/IV therapy such as vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, homotoxicological preparations and others.
- Nutritional or other IV therapy
- Injection therapies (neural therapy, prolotherapy, trigger point & neuralprolotherapy and more)
- Counselling & energy therapies

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over the counter including supplements, herbal remedies
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently
- breast feeding

I am seeking medical health care services, including alternative medical therapies with Dr. Eric Arrata, ND and Dr. Rahim Moledina, ND. I hereby request and consent to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, and botanical medicines) on me (or on the patient named, for whom I am legally responsible) by Dr. Eric Arrata, ND and Dr. Rahim Moledina, ND.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Doctor in Alberta has limitations including at this time no prescription privileges and lack of hospital privileges. Consequently, a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest.

I understand that this medical practice uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine.

I understand that it is not recommended that any medical test be purchased without a medical consultation. If I purchase a medical test without a consultation, it is done so at my own risk.

I understand that I am in no way obligated to purchase the products or run labs recommended by Dr. Eric Arrata, ND and Dr. Rahim Moledina, ND. I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, in the practice of Naturopathic Medicine, in the practice of intravenous therapy, in the practice of nutritional and other supplementation, in the practice of hormone therapy, in the practice of any treatment we administer or order there are some risks.

These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from intra-muscular injections, venipuncture or acupuncture.

A Naturopathic Doctor is trained as a general family practitioner. Naturopathic Doctors combine modern laboratory and physical diagnostic tools with natural, nontoxic therapies that encourage the body's inherent healing abilities. Some of the treatments may include nutrition, herbal medicine, homeopathy, counselling, physiotherapy, hormone replacement therapy, hormone reduction therapy, electrotherapy, natural supplementation and other natural remedies.

Nutritional and herbal supplements: at times, your organ systems and tissues may need nutritional and/or herbal support. Make sure to tell your doctor about any medications you are currently taking so that drug/herb/supplement interactions are minimized. Potential side effects of any herb/supplement recommended to you will be discussed your doctor.

All medical tests, supplements, and consults are non-refundable. All patients must give 48 hours' notice for cancelled appointments. Missed appointments will be billed to the patient at 100% the cost of the visit.

Patient's full name (please print) ______________________________
First Middle Last

Date of consent ______________________________
Day Month Year

Signature of patient (or legal guardian) X ______________________________