The Knee Clinic Intake Form

Welcome to the Knee Clinic!

Please complete the following questionnaire so that we can best determine the level of care we are able to provide to you. If we do not believe your condition will respond to what we can offer, we will refer you to the appropriate healthcare provider.

PERSONAL DEMOGRAPHICS

Date _____

Name: _____ / _____ / _____ _____
Last Name First Name Middle Initial Preferred Name

Date of Birth: _____ /_____ /_____ Sex: _____ Height: _____ Weight: _____
YYYY MM DD

Healthcare #: _____ Province: ❑ AB ❑ Other: _____

Occupation: _____ Marital Status: _____

Home Address: _____ City: _____ Postal Code: _____

Phone #s: Home _____ Cell _____ Work _____

Email Address: _____

Do you consent to receiving emails regarding appointment reminders, health information, and clinic updates? ❑ Yes ❑ No

Emergency Contact: _____
Name Relationship Phone Number

Insurance Provider: _____ Policy/Group #: _____ ID#: _____

Policy Holder Name: _____ Date of Birth: _____

Family Physician (G.P.): _____
Name Location Phone Number

Were you referred to us by your family physician? ❑ Yes ❑ No

Do you consent to details of your case being shared with your family physician? ❑ Yes ❑ No

We take photos of all patients. If you do not wish to have your photo taken, please check the box: ❑

Have you heard our radio ad? ❑ Yes ❑ No

If not, what form of advertising brought you into the clinic?

❑ Google ❑ Facebook ❑ Instagram ❑ TV ❑ Online News/Newspaper ❑ Other _____

❑ Tradeshow/Expo: _____ ❑ Referred by Friend/Family - Name: _____

Is your complaint the result of a motor vehicle collision? ❑ No ❑ Yes; please note that we do not accept external MVA cases. Is your complaint the result of a workplace injury? ❑ No ❑ Yes; please note that we do not accept WCB cases.

Patient Information:

Our healthcare team meets regularly for the purpose of improved patient care.

Do you consent to details of your case being shared among our healthcare team? ❑ Yes ❑ No Please initial here: ☐

Missed Office Visits:

As a courtesy, we ask that a minimum of 24 hours' notice be provided when cancelling or rescheduling appointments. In the event of a missed appointment or a late cancellation with less than 24 hours' notice, a Missed Office Visit Fee of $65 may be charged to your account. Please initial here: ☐

PRESENTING COMPLAINT

1. What is your presenting complaint (e.g. Left knee pain, right shoulder instability)?

   _____

2. Describe the nature of your complaint, noting when and how it first occurred.

   _____

   _____

   _____

3. How frequently does your complaint pain you? _____
4. At what time of day is your complaint at its worst? _____
5. What seems to make your complaint worse? _____
6. What seems to make your complaint better? _____
7. Have you had any previous treatment for this complaint?

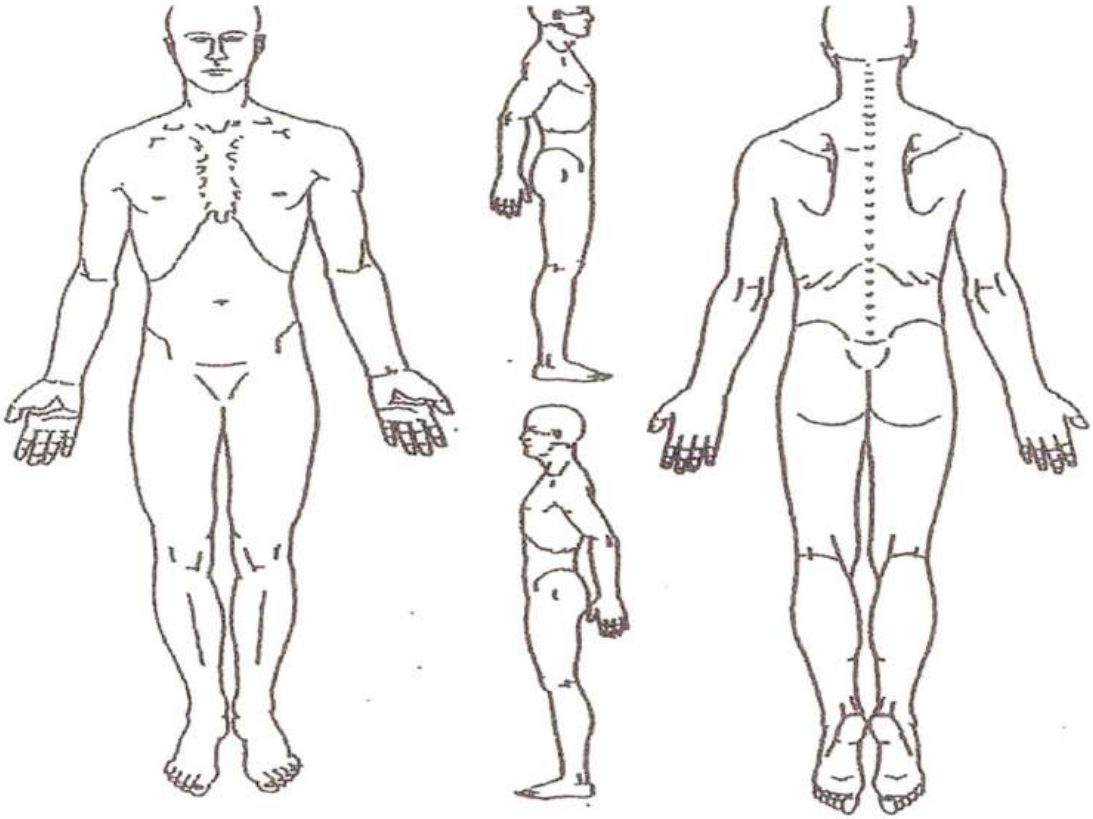
   ❑ No ❑ Yes; please list: _____

8. On the scale below, circle the location that best represents the average severity of pain you've experienced over the past week:

   No pain 0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10 The Worst Pain Ever Possible

9. How would you characterize your pain? ❑ Dull ❑ Achy ❑ Sharp ❑ Stabbing ❑ Burning ❑ Other: _____
10. Does your knee: ❑ Lock ❑ Give out ❑ Swell ❑ Make cracking noises ❑ Pain you at night
11. On the body diagrams below, mark the areas where you feel the following sensations using their corresponding symbols:

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



HEALTH INFORMATION

What are your treatment goals?

_____

_____

Medical Conditions and Health Concerns: List all medical conditions you have been diagnosed with or are being managed for.

_____

_____

_____

Surgeries/Hospitalizations: List all major surgeries and hospitalizations, including the date.

_____

_____

_____

Allergies: List all known drug, food, and environmental allergies.

_____

_____

Current Medications: List all prescription & over the counter medications that you take.

Name	Dosage	For what
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements/Vitamins/Herbals: List all herbal, nutritional & nutraceutical products that you take.

Name	Dosage	For what
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Activity: Rate your current level of weekly physical activity:

- ❑ Regular exercise/activity (>150 minutes of moderate to vigorous exercise per week)
- ❑ Some exercise/activity (30-150 minutes of moderate to vigorous exercise per week)
- ❑ Sedentary (<30 minutes of moderate to vigorous exercise per week)

Please list the types of exercise/activity that you regularly participate in (including frequency):

_____

_____

_____

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
- ❑ Cancer

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
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Loss of strength
- ❑ Muscle twitches

NEUROLOGIC

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

SKIN RELATED

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

CARDIOVASCULAR

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

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

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

GENITOURINARY

- ❑ Trouble urinating
- ❑ Incontinence
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Blood in urine
- ❑ Sores on genitals

MALE GENITOURINARY

- ❑ Prostate trouble
- ❑ Testicular trouble
- ❑ Erectile dysfunction

FEMALE GENITOURINATY

- ❑ Hot flashes
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Irregular/absent cycle
- ❑ Cramping
- ❑ Backache
- ❑ Menopause
- ❑ Vaginal discharge
- ❑ Swollen breasts
- ❑ Lump in breasts

Are you currently on birth control?
❑ Yes ❑ No

Are you currently pregnant?
❑ Yes ❑ No

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits – Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

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 discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area. .
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives – Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks

Questions or Concerns – Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____

Patient Name (print)

_____ _____ _____

Patient/Guardian Signature | Date | Chiropractor Signature