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 health-care provider in a timely manner

Date _____

PERSONAL INFORMATION

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male ☐ Female ☐

Home Address _____ City _____

Postal Code _____ Email Address _____

Phone #'s: Home _____ Cell _____ Bus _____

Birth Date _____ /_____ /_____ Height: _____ Weight: _____ Marital Status ☐ M ☐ S ☐ W ☐ D
Y M D

Current Occupation: _____

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.

Emergency Contact_____
Name Phone Number Relationship

Whom can we thank for your referral? We would like to send them a token of our appreciation. _____

Is this a workplace injury? ☐ Yes ☐ No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? ☐ Yes ☐ No If yes, additional intake forms are required.

The healthcare team in this clinic meets regularly to discuss interdisciplinary co-treatment of our patients. If you **do not** wish us to discuss your case, 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

Missed office Visits:
A charge of $62 will be made in the event of a missed office visit, or if less than 24 hours' notice is given when canceling an appointment.

Re-examinations:
Re-examinations are done in the event of a six month time lapse between office visits

HEALTH INFORMATION

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

☐ Yes For what reason? _____

What approach was taken? _____

☐ No

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

_____

_____

3. What seems to make the problem better? _____

4. What seems to make the problem worse? _____

5. What type of pain is it? (Please check)

☐ Sharp ☐ Stabbing ☐ Achy ☐ Burning ☐ Dull ☐ Diffuse ☐ Localized

6. Does the pain radiate? ☐ Yes ☐ No

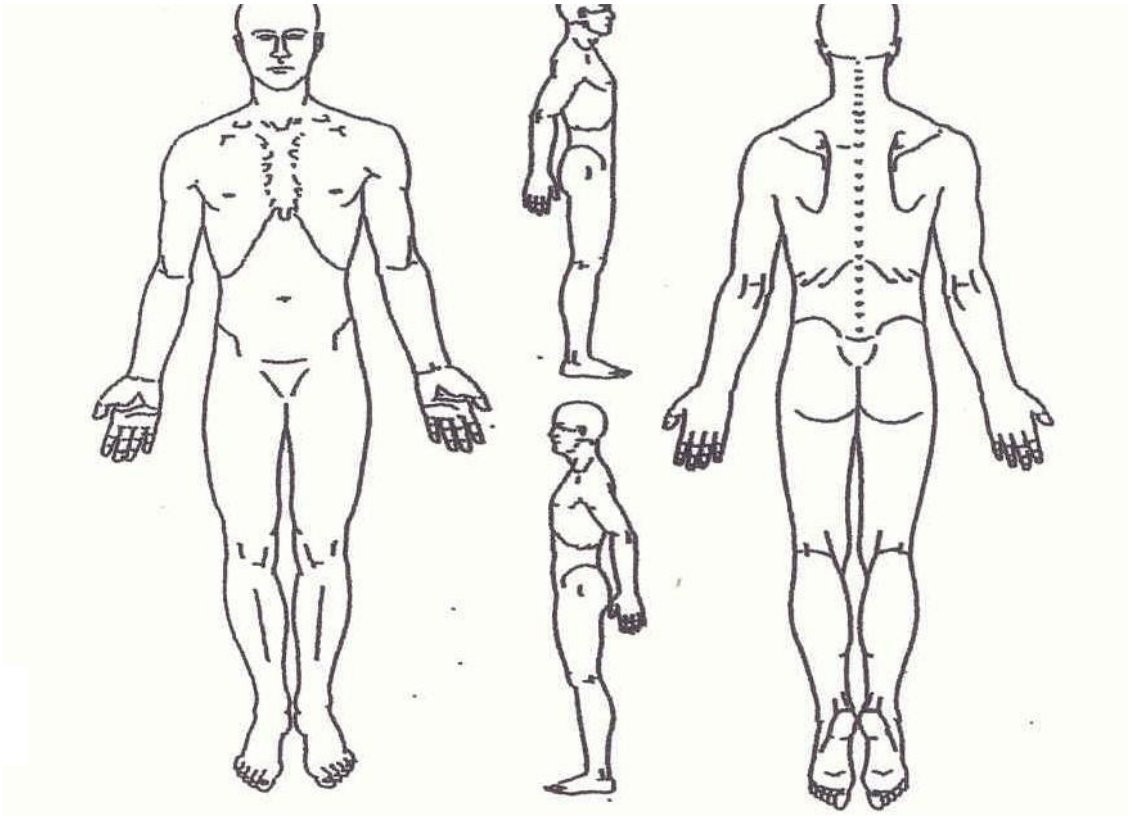
7. At what time of the day does your pain seem to be at its worst? _____

8. Does your knee: (Please check)

☐ Lock ☐ Make cracking noises ☐ Give out on you

9. Mark the areas on the body drawings 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
	\\\\\	++++++	oooooooo	bbbbb	sssss



10. Using the line scale provided below rate the pain you are experiencing **now**

No 0=====1=====2=====3=====4=====5=====6=====7=====8=====9=====10 Severe
Pain Pain

PHYSICAL HISTORY

Please mark a **1** beside any conditions you have had in the **past**
Please mark a **2** beside any condition that you have **presently**

Musculoskeletal system

____ Neck problems
____ Upper back problems
____ Shoulder problems
____ Elbow/wrist problems
____ Low back problems
____ Knee problems
____ Ankle/foot
____ Arthritis

Nervous system

____ Numbness
____ Loss of feeling
____ Headaches
____ Dizziness
____ Fainting
____ Confusion
____ Depression
____ Forgetfulness

Cardio-Vascular-Resp.

____ Chest pain
____ High blood pressure
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm/blood
____ Lung problems
____ Varicose veins
____ Diabetes
____ Hypoglycemia

Genito-Urinary system

____ Painful urination
____ Excessive urine
____ Scanty urine
____ Discolored urine

Female

____ Premenstrual syndrome
____ Abnormal vaginal discharge
____ Abnormal vaginal bleeding
____ Pregnancy
____ Breast pain, and/or lumps

Gastrointestinal system

____ Poor appetite
____ Excessive hunger
____ Abdominal pain
____ Excessive thirst
____ Nausea/vomiting
____ Diarrhea
____ Constipation
____ Bloody/black stool
____ Liver/gallbladder trouble
____ Weight trouble

Ear, Eyes, Nose, Throat

____ Eye problems
____ Vision problems
____ Ear discharge
____ Ear pain
____ Ear ringing
____ Hearing loss
____ Sore throat
____ Allergies
____ Hoarseness

Your first visit to the office includes both an initial consultation as well as an office visit. At the discretion of the doctor, your first visit may not consist of actual treatment.

Attire/Hygiene

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.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

● **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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date_____ 20____
Signature of patient (or legal guardian)

_____ Date_____ 20____
Signature of Chiropractor

KOOS KNEE SURVEY

INSTUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities.
Answer every question by ticking the appropriate box, only **one box** for each question. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms

These questions should be answered thinking of your knee symptoms during this last week.

	Never	Rarely	Sometimes	Often	Always
S1. Do you have swelling in your knee?					
S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?					
S3. Does your knee catch or hang up when moving?					
S4. Can you straighten your knee fully?					
S5. Can you bend your knee fully?					

Stiffness

The following questions concern the amount of joint stiffness you have experienced in your knee during the last week. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

	None	Mild	Moderate	Severe	Extreme
S6. How severe is your knee joint stiffness **first thing in the morning?**					
S7. How severe is your knee stiffness after sitting, lying or resting **later in the day?**					

Pain

	Never	Monthly	Weekly	Daily	Always
P1. How often do you experience knee pain?					

What amount of knee pain have you experienced in the last week during the following activities?

	None	Mild	Moderate	Severe	Extreme
P2. Twisting/pivoting on your knee					
P3. Straightening knee fully					
P4. Bending knee fully					
P5. Walking on flat surface					
P6. Going up of down stairs					
P7. At night while in bed					
P8. Sitting or lying down					
P9. Sitting upright					

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced **in the last week** due to your knee.

	None	Mild	Moderate	Severe	Extreme
A1. Descending stairs					
A2. Ascending stairs					
A3. Rising from sitting					
A4. Standing					
A5. Bending to floor/picking up objects					
A6. Walking on a flat surface					
A7. Getting in/out of car					
A8. Going shopping					
A9. Putting on socks/stockings					
A10. Taking off socks/stockings					
A11. Rising from bed					
A12. Lying in bed (turning over, maintaining knee position					
A13. Getting in/out of bath					
A14. Sitting					
A15. Getting on/off toilet					

For each of the following activities please indicate the degree of difficulty you have experienced **in the last week** due to your knee.

	None	Mild	Moderate	Severe	Extreme
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)					
A17. Light domestic duties (cooking, dusting, etc.)					

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced **in the last week** due to your knee.

	None	Mild	Moderate	Severe	Extreme
SP1. Squatting					
SP2. Running					
SP3. Jumping					
SP4. Twisting/pivoting on your injured knee					
SP5. Kneeling					

Quality of life

	Never	Monthly	Weekly	Daily	Always
Q1. How often are you aware of your knee problem					

	Never	Mildly	Moderately	Severely	Totally
Q2. Have you modified your lifestyle to avoid potentially damaging activities to your knee?					
Q3. How much are you troubled with lack of confidence in your knee?					
Q4. In general, how much difficulty do you have with your knee?					