Soltis Family CHIROPRACTIC

Patient Information--KNEE

Legal Name _____ Preferred Name _____

Birth Date _____/_____/_____ Age _____ Height _____ Weight _____

Address _____

Cell Phone _____ Email Address _____

Marital Status S M D W Spouse Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Are there any other family members/friends who are involved in your health/financial decisions?

If so: Name/Contact Information _____

_____

Occupation (Current or Previous) _____ Retired? Y N

How did you hear about our office? Circle One: TV Facebook Seminar Mailer Other _____

_____

What is the main health concern you are coming in for today? _____

When did your symptoms begin? _____

Is there anything that makes them worse? _____

Is there anything that makes them better? _____

Is this condition interfering with any of the following areas? (circle all that apply)

Work Sleep Daily Routine Chores Lifting Exercise Shopping Other: _____

How would you describe your symptoms? (circle all that apply)

Stabbing/Sharp Electric Shocks Cold Tingling Pins + Needles Dead Feeling Throbbing

Burning Stinging Achy Numb Swelling Fatigue Cramping Grinding Limping Weak

Frequency of your symptoms

___ Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (25% or less)

On average, at what level would you rate your overall knee pain?

NONE 1 2 3 4 5 6 7 8 9 WORST POSSIBLE PAIN

How serious and committed are you about taking care of this concern/condition?

NONE 1 2 3 4 5 6 7 8 9 WORST POSSIBLE PAIN

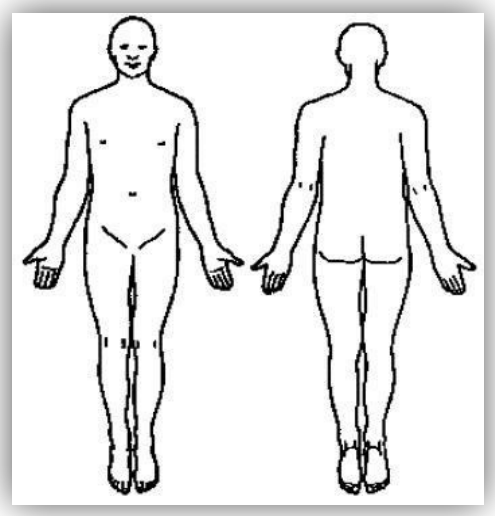
Please indicate on the drawings the body area(s) where you are currently experiencing symptoms

Which knee is bothering you?

___ Left

___ Right

___ Both



Has your condition interfered with daily activities (walking, going up/down stairs, prolonged standing, transitioning from sitting to standing) for at least six (6) months? _____

Have you tried pain and/or anti-inflammatory medications for at least 3 months without gaining long term relief from your symptoms (Tylenol, Aleve, Meloxicam, Capsaicin Cream, Hemp/CBD Cream, etc.)?
_____

Have you attempted physical therapy to the affected knee, or participated in a personal exercise program without long-term relief from your symptoms? _____

Have you used a knee brace without long-term relief of your symptoms? YES NO
If yes, what type of knee brace? _____

_____

Soltis Family CHIROPRACTIC

Have you had an MRI performed on your legs, knees, or feet? YES NO
If yes, when? _____

Have you tried steroid or cortisone injection(s) without long-term relief? YES NO
If yes, how many? _____

Has your doctor ever drained excess fluid from the affected knee(s)? YES NO
If yes, which knee was it? _____Did it help with pain relief? _____

Have you had any other surgical procedure done to your legs, knees, or feet? YES NO
If yes, please list the procedures and approximate dates _____
_____

_____

Comprehensive Health History

Primary Care Physician Name _____
Clinic Name / Phone Number _____
Do we have your permission to send them records of your visits here if they request us to? YES NO
Please list any serious medical conditions you have had (diagnosed conditions, etc.) _____
_____
_____

Circle Yes or No for each condition listed below:

Y N Lower Back Pain	**Y N** Leg or Foot Pain/Numbness	**Y N** Spinal Surgery
Y N Knee Surgery	**Y N** Vascular Leg Problems	**Y N** Vascular Surgery
Y N Leg Fractures	**Y N** Foot Surgery	**Y N** Diabetes (Last A1C=_____)
Y N Neuropathy	**Y N** High Cholesterol	**Y N** Heart Attack
Y N Heart Problems	**Y N** Stroke	**Y N** Kidney Issues
Y N Dialysis	**Y N** Herniated Disc	**Y N** Sciatica
Y N Spinal Stenosis / Arthritis	**Y N** Neck Pain	**Y N** Gout
Y N Shingles	**Y N** Joint Replacement	**Y N** Hand Problems

Soltis Family CHIROPRACTIC

Please list any medications and/or vitamins you are currently taking (or attach a list to this form)

_____ _____

_____ _____

_____ _____

Are you currently taking a **blood thinner**? (Coumadin, Lovenox, Heparin, etc.) YES NO

Are you currently taking a **statin**? (Atorvastatin, Lipitor, Crestor, Simvastatin, etc.) YES NO

Do you have an **electrical implant** of any kind? (spinal stimulator, bladder stimulator, etc.) YES NO

Alcohol Use: __ Never __ Rarely __ Moderately __ Daily # _____ __ Former User

Tobacco Use: __ Never __ Rarely __ Moderately __ Daily # _____ __ Former User

Other Drug Use: __ Never__ Rarely __ Moderately __ Daily # _____ __ Former User

Do you Exercise regularly? YES NO If yes, how long and how often? _____

What type of exercise? _____

Soltis Family CHIROPRACTIC

Functional Goals Survey

Please take several minutes to answer these questions so we can best serve you.

How many doctors have you seen for this condition? _____

What recommendations did they give you (medications, supplements, therapies, treatments, etc.)?

_____

_____

_____

Have the things you have done so far for this condition helped? Circle one

Yes, a lot Yes, some No, not at all I'm not sure

List some activities/hobbies you can no longer do, or are struggling with because of this condition. Please be specific.

1. _____ 2._____
3._____ 4._____
5._____ 6._____

If this problem continues to progress, what do you envision your life will be like? Please be specific.

_____

_____

What would be different if this problem was gone? Please be specific.

_____

_____

In order for the treatments in our office to be considered successful to you, what would need to happen? What are the results you would like to see?

_____

_____

In the last 10 days my knee pain has affected…

1. My ability to walk without assistance 1 2 3 4 5
2. My ability to walk without a limp 1 2 3 4 5
3. The distance I am able to walk 1 2 3 4 5
4. My ability to go up or down stairs 1 2 3 4 5
5. My ability to fall asleep or stay asleep 1 2 3 4 5
6. My balance or stability when walking or standing 1 2 3 4 5
7. My ability to get up from a seated position 1 2 3 4 5

1 = Not Affected, able to complete easily
2 = Slightly Affected, still able to complete
3 = Affected, unable to complete sometimes
4 = Moderately Affected, unable to complete most days
5 = Extremely Affected, never able to complete

8. My ability to complete daily activities around my home (laundry, dishes, etc.) 1 2 3 4 5
9. My ability to complete errands around town (groceries, appointments, etc.) 1 2 3 4 5
10. My ability to get in and out of a vehicle 1 2 3 4 5

Soltis Family Chiropractic

Acknowledgment of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in **Soltis Family Chiropractic's** Notice of Privacy Practices. **Soltis Family Chiropractic** is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Those individuals or parties that could have access to Patient Health Information at **Soltis Family Chiropractic** include but may not be limited to:

The Staff of **Soltis Family Chiropractic** this includes:

Dr. Jeff Soltis, Dr. Leah Soltis, Lindsay Zabel Office Manager, Jamie Bergstrom and Jamie Thomas CA's.

By signing below, you are acknowledging that you have reviewed a copy of Soltis Family Chiropractic's Notice of Privacy Practices.

Patient Name: _____

Patient Date of Birth: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date: _____

Soltis Family Chiropractic USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____

_____

Signature: _____ Date: _____