Missouri Institute of Regenerative Health

4601 Executive Centre Pkwy, Ste 300, Saint Peters, MO 63376, 636-244-5890

**Application for Knee Pain Treatment** (Please Print Clearly)

|  |
| --- |
| Name: Social Security#: Date: |
| Date of Birth: Age: Sex: M F |
| Address: |
| City: State: Zip Code: |
| Home Phone#: Cell#: |
| E-mail Address: |
| Spouse’s Name: |
| Occupation (Current or Previous): Retired: Y N |
| Clerical: Y N Light Labor: Y N Moderate Labor: Y N Heavy Labor: Y N |
| In Case of Emergency Contact Name: Phone Number: |
| Primary Care Provider: May we contact them Y N |

**PLEASE CHECK THE BOXES OR CIRCLE ALL THAT APPLY TO YOU AND FILL IN THE INFORMATION WHERE NEEDED. Thank you.**

**1.What is your complaint?:** □Knee Pain □Right Knee □Left Knee □Both Knees □ Back Pain

***(If both knees:*** *□Right is worse than left □Left is worse than Right □Equally painful)*

*□ other joint pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**3.Have you been Diagnosed with a Particular Condition (Such as Osteoarthritis)?:** □Yes □No

If “Yes”, what condition?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.When and How did the pain/symptoms begin?** □Gradual Onset □Sudden Onset □Trauma.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.On a scale, how would you rate your symptoms?** (10 is the worst) 1 2 3 4 5 6 7 8 9 10 (Circle).

**6.Circle All That Describe Your Symptoms?:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Stabbing-Sharp | Aching | Burning | Throbbing | Cramping | Stinging | Pins & Needles | Numbness |
| Cold | Dead Feeling | Tiredness | Electric Shocks | Swelling | Tingling | Locking | Unstable/Like Giving out |
| Stiffness after Rest | Stiffness w/Activity | Improves with Movement | Feels like Falling | Other: |  |  |  |

**7.How Frequent are the symptoms?:** □Constant(76 to 100% of the day) □Frequent(51 to 75% of the day)

□Occasional(26 to 50% of the day) □Infrequent(1 to 25% of the day) □No Symptoms(0% of the day)

**8.What Makes the Symptoms Worse?** □Going up stairs □Going down stairs □Prolonged Sitting □Prolonged Standing □Squatting □Lifting □Carrying Heavy Objects □Lying Down □Pushing □Pulling □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9.What Makes the Symptoms Better?** □Nothing □Rest □Exercise □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.Have you had any studies done of the area such as?:** □EMG/Nerve Conduction Study □X-rays □CT Scan □MRIs □Other Studies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so Where and When were the studies done?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**11.Have you had Physical Therapy?** □Yes □No If you have, Where and When?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**12. Have you had a prior consultation or seen anyone else for this condition?:** □Orthopedics □Pain Management □Neurosurgery □Physical Medicine & Rehabilitation □Neurologist □Rheumatologist □Primary Care □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13.Please List All Other Treatments You Have Had for this Condition and if it was Helpful or Not?:**

□Medications/Supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Bracing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Injections:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Chiropractic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Regenerative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Alternative/Other Treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14.Do you exercise regularly?:** □Yes □No. If “yes”, what type of exercise?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15.Please List All your Medical Conditions?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please List All Surgeries you have had?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16. Please list all relevant family history:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use tobacco products?**  *□ Yes □ No*  ***Do you drink alcohol?***  *□ Yes □ No*

**17.Please List any Medications and/or Vitamins you are currently taking, or attach medication list?:**

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**18.Please List Any Allergies you have with associated reactions**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19.Do you also have any of the following issues (Circle all that apply to you):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fatigue | Vomiting | Shortness of Breath | Numbness or Tingling | Rashes | Nervousness/  Anxiety |
| Fever/Chills | Constipation | Chest Pains | Headaches | Joint Swelling | Depression |
| Swallowing Issues | Diarrhea | Incontinence of Urine/Stool | Vision Problems | Muscle weakness | Sleep Issues |
| Nausea | Abdominal Pain | Edema | Easy bleeding/bruising | Excessive Thirst | Unexpected Weight Changes |

**20. Which if the following is true for your condition: (check one of the following):**

|  |  |  |
| --- | --- | --- |
| □It’s getting better on it’s own | □It’s staying the same | □It’s getting worse as time goes |

**21. Check any activities (you used to be able to do when you were feeling better) that are now limited:**

|  |
| --- |
| □Housework □Preparing Meals □Socializing □Driving □Other: |
| □Yard Work □Bathing □Sleeping □Dressing □Other: |
| □Shopping □Exercising □Hobbies □Working |

**22. Have you failed conservative treatments for more than 90 days (3 months)?: □Yes □No**

**23. Have you received a brace for you condition?: □Yes □No**

**24. Would you like to avoid more prescription medicines?: □Yes □No**

**25. Would you like to avoid possible surgery and have treatments to avoid surgery?: □Yes □No**

**26. List the three other main “health goals” that you would like to accomplish:**

|  |
| --- |
| 1. |
| 2. |
| 3. |

1. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
2. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_