reflex
Knee Specialists

REFLEX CONFIDENTIAL HEALTH HISTORY INTAKE FORM

Full Legal Name: _____(Last)/_____(First)/_____(Middle Initial)

How did you first hear about our clinic? _____

If Radio – Please circle one: OPB/NPR/Jazz Radio 750/102.9 The Game 1080 The FAN (Jason Swygard "Swag")

Who is your Primary Care Provider (PCP)? _____ **Phone #:** _____

Reflex will share your records (including chart notes and outcomes) with your PCP, unless otherwise requested.

❒ No, I do not want my records from Reflex shared with my PCP.

Have you been diagnosed or treated for any of the following conditions? *(check all that apply)*

❒ Arthritis
❒ Blood Clots (DVT)
❒ Blood Disorders
❒ Cancer
❒ Diabetes
❒ HIV/AIDS
❒ Heart Disease
❒ Hypertension
❒ Kidney failure
❒ Stroke
❒ Transplant Surgery
❒ Other _____

List previous surgeries NOT knee related: _____

Do you have any known food and/or medication allergies? ❒ No ❒ Yes *(if yes, please indicate below)*

_____

_____

Please list all prescription medications you are currently taking:

_____

_____

What medications do you take to control your knee pain?
Please check all that apply**.**

❒ Tylenol_____
❒ Advil _____
❒ Ibuprofen_____
❒ Motrin _____
❒ Other_____

Approximate Amount_____

Please rate the effectiveness of the medication(s) you are taking for your knee pain:

❒ Never effective
❒ Sometimes effective
❒ Usually effective
❒ Always effective

Are you taking any supplements? ❒ No ❒ Yes
(if yes, please check the supplements you are regularly taking)

❒ Fish oil
❒ Glucosamine/Chondroitin/MSM
❒ Multi-vitamin
❒ Other_____
_____ _____

What is your smoking status? *(if currently smoking, how many packs per day on average?)*

❒ I currently smoke _____packs per day
❒ Former smoker
❒ Non-smoker

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How long have you been experiencing knee pain?

Right Knee _____

Left Knee _____

Please list any prior knee injuries, arthroscopies, or surgeries below *(please include the year if possible):*

Right Knee _____

Left Knee _____

Have you ever had HA Knee Injections?

❒ Right Knee
❒ Left Knee

Approx. date of last injection:

Brand of injection:
❒ Euflexxa
❒ Synvisc
❒ Orthovisc
❒ Other _____

Have you ever had Cortisone Knee Injections?

❒ Right Knee
❒ Left Knee

Approx. date of last injection:

How many injections per knee:
Right Knee _____
Left Knee _____

Have you participated in a knee physical therapy program? *(if yes, indicate date of last visit)*
❒ No ❒ Yes *(if yes, indicate date of last visit):* _____

Have you ever been fitted for or used an off-loading knee brace?
❒ Right Knee
❒ Left Knee

Have you been evaluated for knee pain by an orthopedic surgeon? ❒ No ❒ Yes

If 'yes' what is the *date* of the evaluation and orthopedic surgeons *name*?

_____

If 'yes' what was the recommendation (i.e. arthroscopy, meniscal/ACL repair, knee replacement)?

_____

Please check which activities you currently participate in or have previously participated:

❒ Running ❒ Walking
❒ Golf ❒ Cycling
❒ Basketball ❒ Hiking
❒ Softball ❒ Other_____

Which activities exacerbate your pain on a daily basis? *(please check all that apply)*

❒ Standing ❒ Kneeling
❒ Walking ❒ Bending/squatting
❒ Stairs *(going up)* ❒ Running *(at what distance?)*
❒ Stairs *(going down)* _____ mile(s)

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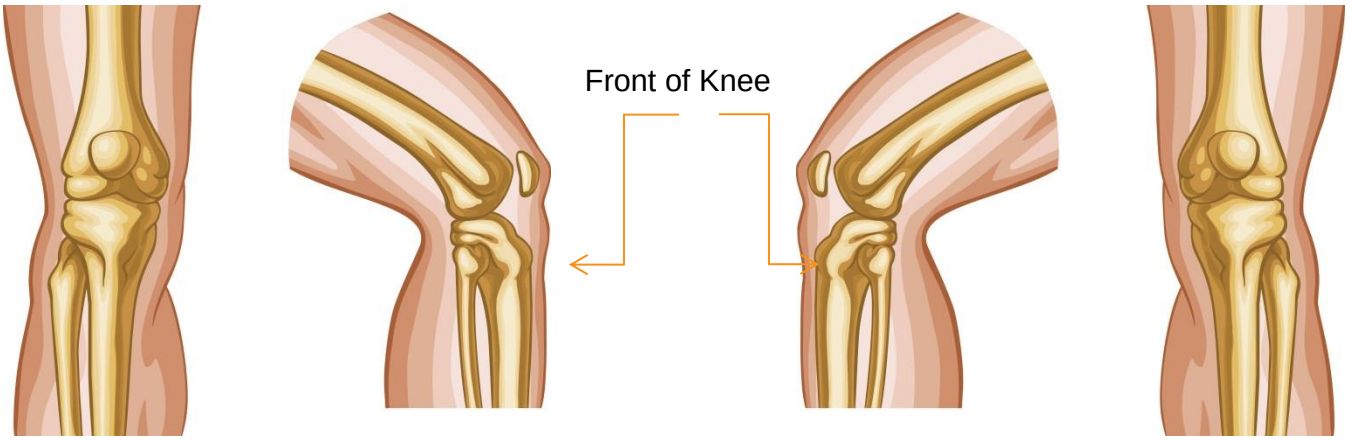
Please circle the area(s) where you experience pain:

Right Knee **Left Knee**



Front View **Side View** **Side View** **Front View**

Does your knee pain limit your activity level? ❒Never ❒Rarely ❒Frequently ❒Constantly

How would you describe your knee pain? Please check all that apply:

❒ Grinding ❒Right ❒Left ❒Both knees
❒ Sharp ❒Right ❒Left ❒Both knees
❒ Aching ❒Right ❒Left ❒Both knees
❒ Tender ❒Right ❒Left ❒Both knees

Do you ever experience swelling in your knee(s)? ❒Never ❒Rarely ❒Frequently ❒Constantly

How frequently do you experience knee pain?

❒ Constantly
❒ Daily
❒ A few times a week
❒ A few times a month

How long does it usually last?

❒ A few seconds
❒ A few minutes
❒ A few hours
❒ All day

❒ Other _____ ❒Right ❒Left ❒Both knees

What is your goal from receiving treatment at Reflex? (ex. Walking 2 miles without pain, returning to a sport etc…)

_____

_____

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Please answer the following questions about your knees based on the pain you experience.

On a scale of 0 (none) to 10 (severe), please rate the following pain levels (please select the most appropriate):	
Daily average pain in right knee	0 1 2 3 4 5 6 7 8 9 10
Worst pain during the week in right knee	0 1 2 3 4 5 6 7 8 9 10
Daily average pain in left knee	0 1 2 3 4 5 6 7 8 9 10
Worst pain during the week in left knee	0 1 2 3 4 5 6 7 8 9 10

Please answer the following questions while thinking of your knee pain symptoms.

On a scale of 0 (none) to 10 (severe), please rate your <u>average</u> pain levels:

	<u>LEFT KNEE</u>	**<u>RIGHT KNEE</u>**
Grinding/clicking with knee movement	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
While walking	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Going up and down stairs	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
At night in bed	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Rising from a chair	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

<u>Office Use Only</u>

Height_____in.
Weight_____lbs.
BMI _____
BP _____mm/Hg