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 (Canzano) KXL 101.1

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
❒ Other _______________________
❒ Diabetes
❒ HIV/AIDS
❒ Heart Disease
❒ Hypertension
❒ Kidney failure
❒ Stroke
❒ Transplant Surgery
❒ Psoriasis (You or family member)

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 <u>all</u> 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____
If yes, how much and how often? ___________________

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____
If yes, how much and how often? ___________________

Please rate the effectiveness of the medication(s) you are taking for your knee pain:
❒ Never effective
❒ Sometimes effective
❒ Usually effective
❒ Always effective

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

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):*

Right Knee ____

Left Knee ____

Have you ever had HA Knee Injections?

❒ Right Knee
Approx. date of last injection: ______________
❒ Left Knee
Approx. date of last injection: ______________

Brand of hyaluronic acid injection:

❒ Euflexxa
❒ Synvisc
❒ Orthovisc
❒ Other ______________________________

Have you ever had Cortisone Knee Injections?

❒ Right Knee
Approx. date of last injection: ______________________
❒ Left Knee
Approx. date of last injection: ______________________

Have you participated in a knee physical therapy program?

❒ 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
(If yes, indicate date you were fit): __________________________

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
❒ Golf
❒ Basketball
❒ Softball
❒ Walking
❒ Cycling
❒ Hiking
❒ Other________________

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

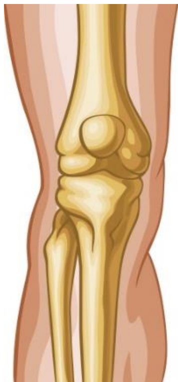
❒ Standing
❒ Walking
❒ Stairs *(going up)*
❒ Stairs *(going down)*
❒ Kneeling
❒ Bending/squatting
❒ Running *(at what distance?)*_____mile(s)

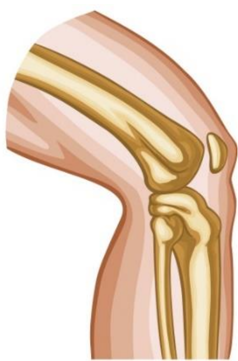
Which of the Following have you ever tried or taken to help reduce your knee pain? *(Please check all that apply)*

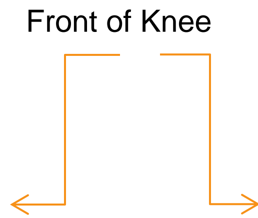
- ❒ Stretching
- ❒ Home Exercise Program
- ❒ Gym/Personal Trainer
- ❒ Biking or Cycling
- ❒ Compression Sleeve
- ❒ Message Therapy
- ❒ Meditation or Mindfulness
- ❒ Nerve Ablation
- ❒ Topical Gel
- ❒ Elliptical
- ❒ Swimming
- ❒ Wedged Shoe Inserts
- ❒ Walking Aids *(cane, walking poles)*
- ❒ Acupuncture
- ❒ Pilates
- ❒ Laser Therapy
- ❒ Ultrasound *(ECSWT)*
- ❒ Resistance Exercise: If *yes, over what time period?* ____________________
- ❒ Diet/Weight Loss
- ❒ Thermal Therapy *(ice or heat)*
- ❒ Hypnosis
- ❒ Kinesio Taping
- ❒ Yoga
- ❒ Counseling/Biofeedback Therapy
- ❒ Electrical Stimulation Therapy
- ❒ Magnet or Copper Bands

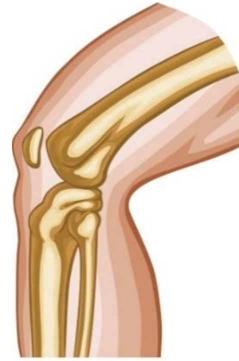
Please circle the area(s) where you experience pain:

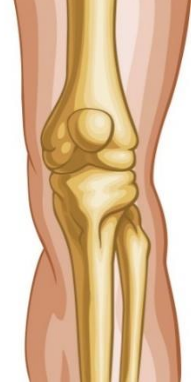
Right Knee **Left Knee**


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
❒ Sharp	❒ Right	❒ Left	❒ Both
❒ Aching	❒ Right	❒ Left	❒ Both
❒ Tender	❒ Right	❒ Left	❒ Both

Do you ever experience swelling in your knee(s)?	❒ Never	❒ Rarely	❒ Frequently	❒ Constantly
Do you ever experience pain/swelling in your fingers & toes?	❒ Never	❒ Rarely	❒ Frequently	❒ Constantly
Do you ever have red and itchy areas on your scalp or skin?	❒ Never	❒ Rarely	❒ Frequently	❒ Constantly

How frequently do you experience knee pain?

- ❐ Constantly
- ❐ Daily
- ❐ A few times a week
- ❐ A few times a month
- ❐ Other ___________________________________

How long does it usually last?

- ❐ A few seconds
- ❐ A few minutes
- ❐ A few hours
- ❐ All day
- ❐ Right ❐ Left ❐ Both knees

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

____

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 average pain levels:

	RIGHT KNEE	**LEFT KNEE**
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

Office Use Only

Height_____________in.
Weight____________lbs.
BMI ___________________
BP ___________________mm/Hg