CENTER FOR NATURAL HEALTHCARE, PLLC

Providing Steps to Wholeness

Knee Patient Evaluation Form

Name: _____

Which knee are you having problems with? ❑ left ❑ right

How long have you had symptoms?_____ Today's Date:_____ Date problem began:_____

1. MY MAJOR COMPLAINT IS: *(check all that apply)*

❑ pain ❑ swelling ❑ giving out ❑ dull ache ❑ loss of motion ❑ grinding

❑ locking ❑ other (please explain) _____

2. WHEN DID THIS PROBLEM START? *(check all that apply)*

❑ gradually ❑ suddenly ❑ vehicle accident ❑ while at work ❑ not sure

❑ while playing sports (which sport?) _____

IF YOU HAVE BEEN EXPERIENCING PAIN, PLEASE ANSWER THIS SECTION. IF NOT, PLEASE GO TO QUESTION 8.

3. THE PRIMARY LOCATION OF PAIN IS: *(check all that apply)*

❑ knee cap ❑ throughout the knee ❑ outer side ❑ inner side ❑ back ❑ deep inside

4. WHEN DOES THE AFFECTED KNEE HURT? *(please check one)*

❑ infrequently ❑ constantly ❑ when active

4A. DOES THE AFFECTED KNEE HURT WHEN YOU ARE RESTING?

❑ yes ❑ no

5. DOES THE PAIN IN THE AFFECTED KNEE OCCUR AT NIGHT?

❑ yes ❑ no

5A. WHEN THIS PAIN OCCURS, DOES IT AWAKEN YOU?

❑ yes ❑ no

6. WHEN IS THE PAIN MADE WORSE? *(check all that apply)*

❑ sitting ❑ standing ❑ walking ❑ climbing stairs ❑ getting up ❑ running ❑ during physical exercise

7. THE PAIN IS RELIEVED BY: *(check all that apply)*

❑ nothing ❑ rest ❑ moving the knee ❑ heat therapy ❑ cold therapy ❑ activity

❑ medicine - if so, what kind? _____

8. IS THE AFFECTED KNEE EVER SWOLLEN? *(check all that apply)*

❑ never ❑ infrequently ❑ constantly ❑ only after exercise or use ❑ only at time of original injury

9. ARE THERE ANY GRATING OR GRINDING NOISES OR SENSATIONS IN THE JOINT?

❑ none ❑ when climbing stairs ❑ when descending stairs ❑ when getting up from chair
❑ when walking ❑ when doing deep knee bends

10. WHEN DOES YOUR KNEE LOCK? (Get stuck)

❑ never ❑ at first, not now ❑ occasionally ❑ frequently ❑ continually

11. WHEN KNEE GIVES OUT OR BUCKLES IT FEELS LIKE: *(check all that apply)*

❑ this does not apply ❑ kneecap shifts ❑ entire knee shifts ❑ something inside the knee shifts

12. WHAT IS THE RANGE OF MOTION IN YOUR AFFECTED KNEE?

❑ same as ever ❑ unable to fully straighten the joint ❑ unable to fully bend or flex the joint

13. MOBILITY OF THE JOINT: ❑ able to walk normally ❑ walk with a limp

14. WHAT ACTIVITIES ARE YOU UNABLE TO DO? *(check all that apply)*

❑ walk a 1/2 block ❑ walk a block ❑ walk a 1/2 mile ❑ walk greater than a 1/2 mile
❑ climb ❑ jump ❑ squat ❑ run ❑ not affected/does not apply

15. ARE YOU USING WALKING AIDS? *(check all that apply)*

❑ none ❑ cane ❑ crutches ❑ wheelchair ❑ brace ❑ walker

16. HAVE YOU BEEN TREATED BY A PHYSICIAN FOR THIS PROBLEM? ❑ YES ❑ NO

Doctor's Name/ Type of Doctor:_____

Address:_____

Diagnosis:_____

Treatment:_____

17. HAVE YOU BEEN TREATED AT AN EMERGENCY ROOM FOR THIS PROBLEM? ❑ YES ❑ NO

Hospital: _____ Address: _____

18. HAVE YOU HAD X-RAYS TAKEN FOR THIS PROBLEM? ❑ YES - *if yes, please list below* ❑ NO

Date/s:_____ Location/s:_____

Results:_____

19. HAVE YOU HAD AN ARTHROGRAM? (Dye test) ❑ YES - *if yes, please list below* ❑ NO

Date/s:_____ Location/s:_____

Results:_____

20. HAVE YOU HAD ANY ARTHROSCOPY OR ARTHROSCOPIC SURGERIES PERFORMED ON THE AFFECTED KNEE? (Looking into the joint) ❑ YES - *if yes, please list below* ❑ NO

Date/s:_____ Doctor/s:_____ Type/s:_____

Results: _____ Complications: _____

21. HAVE YOU HAD ANY OPEN SURGERY ON THE JOINT? ❑ **YES -** ***if yes, please list below*** ❑ **NO**

Date/s:_____ Doctor/s:_____ Type/s:_____

Results: _____ Complications: _____

22. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS? ❑ **YES -** ***please check below*** ❑ **NO**

❑ heart disease ❑ lung disease ❑ rheumatoid arthritis ❑ other arthritis ❑ inherited disease ❑ diabetes
❑ circulation problems ❑ high blood pressure ❑ stomach ulcer ❑ gout ❑ cancer ❑ bleeding tendency
❑ other (describe) _____

23. HAVE YOU BEEN UNDER A DOCTOR'S CARE IN THE LAST 2 YEARS? ❑ **YES** ❑ **NO**

Doctor: _____ Address: _____

Reason: _____

24. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

Medication/Dosage:_____ Medication/Dosage:_____

Medication/Dosage:_____ Medication/Dosage:_____

25. HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE PAST SIX MONTHS?

❑ **YES -** ***if yes, please check below*** ❑ **NO**

❑ cortisone pills or shots ❑ high blood pressure pills ❑ water pills ❑ heart medicine ❑ insulin

26. PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION:

Allergy/Reaction:_____ Allergy/Reaction:_____

Allergy/Reaction:_____ Allergy/Reaction:_____

27. PLEASE LIST ANY MAJOR SURGERIES YOU HAVE HAD/ANY COMPLICATIONS THAT OCCURRED:

Surgery:_____ Complications:_____

Surgery:_____ Complications:_____

Surgery:_____ Complications:_____

28. PLEASE RATE YOUR OVERALL LEVEL OF PHYSICAL HEALTH:

❑ excellent ❑ very good ❑ good ❑ fair ❑ poor **ARE YOU PREGNANT?** ❑ yes ❑ no

HEIGHT:____ WEIGHT:____ DOMINANT HAND: ❑ right ❑ left ❑ both **DO YOU SMOKE?** ❑ yes ❑ no

DO YOU DRINK ALCOHOL? ❑ yes ❑ no ***If yes, how often?*** ❑ daily ❑ occasionally ❑ rarely

29. WHO REFERRED YOU TO US FOR THIS EVALUATION AND CARE?

❑ physician ❑ former patient ❑coach/trainer ❑ yellow pages ❑ word of mouth ❑ other_____

Name of person who referred you:_____ Date:_____

HAVE YOU EVER HAD:

Broken bones? ❑ yes ❑ no *If yes, which bones and when?* _____

Head injuries? ❑ yes ❑ no *If yes, when?* _____

Neck injuries? ❑ yes ❑ no *If yes, when?* _____

Back injuries? ❑ yes ❑ no *If yes, when?* _____

HAS ANY MEMBER OF YOUR FAMILY EVER HAD:

CANCER	❑ yes	❑ no	*If yes, relation?*_____
HEART DISEASE	❑ yes	❑ no	*If yes, relation?*_____
LUNG DISEASE, TB, ETC.	❑ yes	❑ no	*If yes, relation?*_____
DIABETES	❑ yes	❑ no	*If yes, relation?*_____

DESCRIBE BRIEFLY HOW CURRENT INJURY OCCURRED:

_____

_____

_____

_____

_____

HAVE YOU HAD A PREVIOUS PROBLEM IN THIS AREA? If so, please describe:

_____

_____

_____

_____

_____

HAVE YOU LOST TIME FROM WORK BECAUSE OF THIS INJURY?

_____

_____

_____

_____

BRIEFLY DESCRIBE YOUR JOB ACTIVITIES? *(Lifting, pushing, pulling, etc.)*

_____

_____

_____

_____

_____

Natural Medicine

• Chiropractic Treatment • Acupuncture • Detoxification • Lab & Food Sensitivity Testing • Nutritional Counseling
• Laser • Personalized Health Coaching • Nutritional/Herbal Therapy • Hormone Testing/Treatment

Dr. Joseph H. Sevlie, D.C., FASA
1626 West 3rd Street • Red Wing, MN 55066 • 651-388-1211