Fusion Medical Center- 6298 Linton Blvd., Suite 100 Delray Beach, FL 33484

Application for Knee Pain Treatment (Please Print Clearly)

Name:		Social Security#:		Date:
Date of Birth:	Age:	Sex: M F	Marital Status M S D W	# of children:
Address:				
City:		State:	Zip:	
Home Phone #:		Cell #:		
E-mail Address:				
Spouse's Name:				
Occupation (Current or Previous)				Retired: Y N
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N
In Case of Emergency Contact Name			Phone Number:	

TELL US ABOUT YOUR PAST HEALTH:

Y	N	← Lower Back Pain	Y	N	← Diabetes (A1C = _____)	Y	N	← High Cholesterol
Y	N	← Leg or Foot Pain/Numbness	Y	N	← Hand Problems	Y	N	← Shingles
Y	N	← Prior Spinal Surgeries	Y	N	← Neuropathy	Y	N	← Knee Surgery
Y	N	← Spinal Fractures	Y	N	← Heart Attack	Y	N	← Kidney issues or Dialysis
Y	N	← Spinal Stenosis	Y	N	← Heart Problems	Y	N	← Gout
Y	N	← Spinal Arthritis	Y	N	← High / Low Blood Pressure	Y	N	← Hip Surgery
Y	N	← Sciatica	Y	N	← Vascular Leg Problems	Y	N	← Leg Fractures
Y	N	← Neck Pain	Y	N	← Vascular Surgery _____	Y	N	← Joint Replacement
Y	N	← Herniated Disc	Y	N	← Stroke	Y	N	← Foot Surgery

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU ARE CURRENTLY TAKING, OR ATTACH MED LIST:

_____
_____
_____
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PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:
NAME OF YOUR PRIMARY CARE PHYSICIAN:

MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT?: ◻ YES ◻ NO	
PLEASE LIST BELOW ANY **BACK, KNEE, OR LEG SURGERIES** YOU'VE HAD?	
HAVE YOU HAD AN **EMG** PERFORMED ON YOUR LEGS/FEET? ◻ NO	◻ YES - WHEN:
DO YOU EXERCISE REGULARLY? ◻ NO	◻ YES - WHAT:
ARE YOUR SYMPTOMS **WORSE AT NIGHT?** ◻ NO	◻ YES – AROUND WHAT TIME?:

WHAT KIND OF PROBLEM(S) ARE YOU HAVING: (If one knee joint describe the problem, if two knee joints describe the problem)
ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS (10 is the worst) 1 2 3 4 5 6 7 8 9 10
WHEN DID THIS BEGIN: _____   **WHAT HAVE YOU DONE TO TRY TO HELP YOUR PROBLEM (EX: OVER THE COUNTER OR PRESCRIPTION MEDS, INJECTIONS, SURGERIES, ETC.)**
WHAT MAKES IT BETTER:
WHAT MAKES IT WORSE:

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

WHAT DO <u>YOU THINK</u> IS CAUSING YOUR PROBLEM:
IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)

WORK	**SLEEP**	**DAILY ROUTINE**	**CHORES**	**WALKING**	**STANDING**	**SHOPPING**

<u>How would you describe your average knee pain over the past week?</u>

No pain **Worst possible pain**

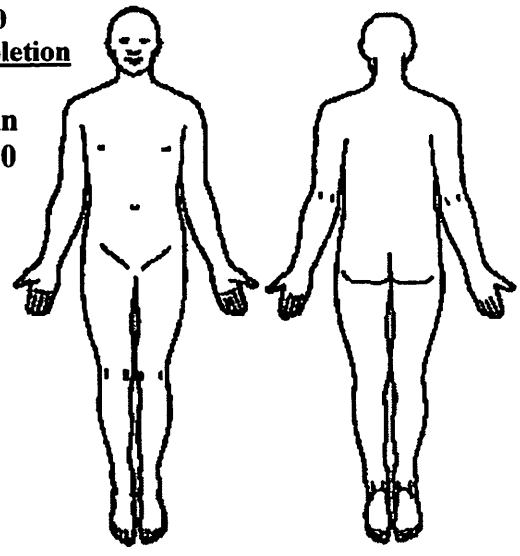
0 1 2 3 4 5 6 7 8 9 10

<u>Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?</u>

No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:
Use the Following Colors:
Pain= Blue
Numbness/Tingling= Yellow
Stiffness= Green



Which of 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 worst as time goes by
List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited:		
List the three main "health goals" that you would like to accomplish:		
1)		
2)		
3)		

A. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
B. 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 OUR OFFICE?

_____

Walking Scale Questionnaire

These questions ask about limitations to your walking due to knee pain during the past 2 weeks . For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of you consultation.

In the past 2 weeks how much has your knee pain...	Not at all	A little	Moderately	Quite a bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up or down stairs?	1	2	3	4	5
Made standing when doing things more difficult?	1	2	3	4	5
Limited your balance when standing or walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors, eg holding on to furniture, using a cane, etc?	1	2	3	4	5
Made it necessary for you to use support when walking outdoors, eg using a cane or walker, etc?	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

Thank you for completing this questionnaire

WALKING SCALE DISABILITY SCORE: < NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

Fusion Medical Center
Knee Pain Program Qualification Questionnaire

(Please answer ALL of the following questions by circling one answer per question.)

Thank you for completing this questionnaire. Please return to the front desk.

1. Do you experience knee pain? Right / Left / Both
2. Do you experience knee pain at rest? Yes / No
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? Yes / No / Unsure
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months? Yes / No
5. Do you have morning knee stiffness lasting 30 minutes or less? Yes / No
6. Do you experience a grinding sensation with knee movement? Yes / No
7. Have you tried pain and/or anti-inflammatory medications (ie: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief? Yes / No
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? Yes / No
9. Have you attempted to lose weight to help with your knee pain? Yes / No
10. Have you used a knee brace without long-term relief? Yes / No
11. Has your doctor ever drained excess fluid from the affected knee(s)? Yes / No
12. Have you tried steroid/cortisone injection(s) to the knee without long-term relief? Yes / No
13. Has your doctor injected FDA-approved Hyalgan, Orthovisc, Supartz, Synvisc-One or the like greater than six months ago? Yes / No If Yes, When:_____
    - If you did have the previously mentioned injection(s); did you receive significant improvement in pain and functional ability (ie easier to walk and/or stand)? Yes / No
    - If you did have the previously mentioned injection(s); were you able to use fewer pain relieving medications for six months afterwards? Yes / No

Fusion Medical Center

Phone: (561) 752-4646 Fax: (561) 737-7664

Authorization for Release of Protected Health Information

Patient Name: _____ Birth Date: _____

Social Security #: _____

I hereby authorize the release of medical records to Fusion Medical Center. My revocation must be in writing, on a form that will be provided to me upon request. I am aware that my revocation will not be effective to the extent that Fusion Medical Center has acted in reliance on this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy regulations, then such information may be re-disclosed and no longer protected by the Federal Privacy regulations. I release Fusion Medical Center and its workforce members from all liability arising from the disclosure of my health information pursuant to this agreement. I have the above and authorize the disclosure of protected health information as stated.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Print Name of Patient/Patient Representative Relationship to Patient