LIGHTHOUSE
MEDICAL CENTER

FILL OUT THE APPLICATION ENTIRELY & LEGIBLY. WE NEED INFORMATION FOR INSURANCE

NAME:	SSN #	DATE

DOB	AGE	SEX M F	MARITAL STATUS M S D W	NO. OF CHILDREN

ADDRESS

CITY	STATE	ZIP

PHONE	EMAIL
SPOUSE NAME	PHONE

YOUR OCCUPATION	RETIRED Y N

CURRENT OR PREVIOUS WORK :	CLERICAL Y N	LIGHT LABOR Y N	MODERATE LABOR Y N	HEAVY LABOR Y N

EMERGENCY CONTACT	PHONE

TELL US ABOUT YOUR HEALTH AND SYMPTOMS (CURRENT OR HAVE BEEN DIAGNOSED)

PLEASE CHECK ALL THAT APPLY

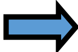
___ LOWER BACK PAIN
___ LEG OR FOOT PAIN/NUMBNESS
___ SPINAL FRACTURES
___ SPINAL ARTHRITIS
___ SPINAL STENOSIS
___ SCIATICA
___SHINGLES
___NECK PAIN
___HAND PAIN
___HERNIATED DISC
___ HAND NUMBNESS
___PLANTAR FASCIITIS
___DIABETES
___HIGH COLESTEROL
___HIGH/LOW BLOOD PRESSURE
___CHEMOTHERAPY (CURRENTLY OR PREVIOUSLY ON)
___ CANCER (CURRENTLY OR PREVIOUSLY DIAGNOSED)

___ HEART PROBLEMS
___HEART ATTACK
___DEGENERATIVE DISC
___VASCULAR LEG PROBLEMS
___VASCULAR SURGERY
___STROKE
___ARTHRITIS IN HANDS/FEET
___BULGING DISC
___MORTON'S NEUROMA
___NEUROPATHY
___KNEE SURGERY
___FOOT SURGERY
___HIP SURGERY
___JOINT REPLACEMENT
___IMPLANTED CORD/BLADDER STIMULATOR
___EXCESSIVE THIRST OR URINATION
___KIDNEY ISSUES OR DIALYSIS

___POOR WOUND HEALING
___PINCHED NERVE
___POOR CIRCULATION
___GOUT
___LEG FRACTURES
___BLOOD DISEASE
___ BLEEDING DISORDER

PLEASE LIST ANY MEDICATION AND/OR VITAMINS CURRENTLY TAKING	
1.	10.
2.	11.
3.	12.
4.	13.
5,	14.
6.	15.
7.	16.
8.	17.
9.	18.

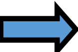
PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD

 ____

NAME OF YOUR PRIMARY CARE PHYSICIAN ____

MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT? ☐ YES ☐ NO

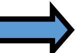
PLEASE LIST BELOW ANY BACK, KNEE OR LEG SURGERIES YOU'VE HAD:

 ____

HAVE YOU HAD AN EMG PERFORMED ON YOUR LEGS/FEET? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

ARE YOUR SYMPTOMS WORSE AT NIGHT? ☐ YES ☐ NO AROUND WHAT TIME? ______________

 DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY CIGARETTES DAILY? ______________

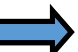
DO YOU DRINK? ☐ YES ☐ NO IF YES, HOW MANY DRINKS PER WEEK? ______________

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE TYPE AND HOW OFTEN:

____

____

____

 LIST ALL ALLERGIES/SENSITIVITIES TO MEDICATIONS, FOOD AND OTHER ITEMS:

ITEMS YOU REACT TO:	REACTION:
______________________	______________________
______________________	______________________
______________________	______________________

PRESENT HEALTH CONDITIONS FOR KNEE PAIN TREATMENT

1. WHAT KIND OF PROMBLEM(S) ARE YOU HAVING? ____

____

____

____

2. ON A SCALE, HOW WOULD YOU RATE YOU SYMPTOMS (10 IS THE WORST)

1 2 3 4 5 6 7 8 9 10

3. WHEN DID THIS BEGIN?

____

4. WHAT MAKES IT BETTER:

____

____

5. WHAT MAKES IT WORSE: ____

____

6. HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)

___STINGS ___ACHE ___COLD ___TINGLING ___TIREDNESS ___SWELLING

___CRAMPING ___BURNING ___NUMBNESS ___STABBING-SHARP ___ELECTRIC-SHOCKS

7. IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

___SLEEP ___WORK ___DAILY ROUTINE ___CHORES ___WALKING

___STANDING ___SHOPPING

8. WHICH OF THE FOLLOWING IS TRUE FOR YOUR CONDITION?

A. IT'S GETTING BETTER ON ITS OWN

B. IT'S STAYING THE SAME

C. IT'S GETTING WORSE AS TIME GOES BY

9. LIST ANY DAYTIME ACTIVITIES (YOU USED TO BE ABLE TO DO WHEN YOU WERE FEELING BETTER) THAT ARE NOW LIMITED:

____

____

____

10. LIST THE THREE MAIN "HEALTH GOALS" THAT YOU WOULD LIKE TO ACOMPLISH:

1.____

2.____

3.____

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PATIENT QUALITY OF LIFE SURVEY FOR KNEE PAIN TREATMENT

PLEASE TAKE SEVERAL MINUTES TO ANWSER THESE QUESTIONS SO WE CAN HELP YOU GET BETTER (CIRCLE AS MANY THAT APPLY)

1. HOW HAVE YOU TAKEN CARE OF YOUR HEALTH IN THE PAST?

A. MEDICATIONS B. ROUTINE MEDICAL C. NUTRITION/DIET D. VITAMINS

E. EMERGENCY ROOM F. EXERCISE G. HOLISTIC CARE H. CHIROPRACTIC

I. OTHER (PLEASE SPECIFY): ____________________

2. HOW DID THE PREVIOUS METHOD(S) WORK OUT FOR YOU?

A. BAD RESULTS B. SOME RESULTS C. GREAT RESULTS D. NOHING CHANGED

E. DID NOT GET WORSE F. DID NOT WORK VERY LONG G. STILL TRYING H. CONFUSED

3. HOW HAVE OTHERS BEEN AFFECTED BY YOUR HEALTH CONDITION?

A. NO ONE IS AFFECTED B. HAVEN'T NOTICED ANY PROBLEM

C. THEY TELL ME TO DO SOMETHING D. PEOPLE AVOID ME

4. WHAT ARE YOU AFRAID THIS MIGHT BE (OR BEGINNING) TO AFFECT (OR WILL AFFECT) ?

A. JOB B. KIDS C. FUTURE ABILITY D. MARRIAGE E. SELF-ESTEEM

F. SLEEP G. TIME H. FINANCES I. FREEDOM

5. ARE THERE HEALTH CONDITIONS YOU ARE AFRAID THIS MIGHT TURN INTO?

A. NEED SURGERY B. CHRONIC FATIGUE C. DEPRESSION D. FIBROMYALGIA

E. ARTHRITIS F. DIABETES G. CANCER H. HEART DISEASE

I. FAMILY HEALTH PROBLEMS

6. HOW HAS YOUR HEALTH CONDITION AFFECTED YOU JOB, RELATIONSHIPS, FINANCES, FAMILY OR OTHER ACTIVITIES?

PLEASE GIVE EXAMPLES: ____________________

____

____

____

7. WHAT HAS THAT COST YOU? (TIME, MONEY, HAPPINESS, FREEDOM, SLEEP, PROMOTION ETC…)

GIVE 3 EXAMPLES: ____________________

____

____

____

8. WHAT ARE YOU MOST CONCERNED WITH REGARDING YOUR PROBLEM? ____________________

____

____

____

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PATIENT QUALITY OF LIFE SURVEY FOR KNEE PAIN TREATMENT

9. WHERE DO YOU PICTURE YOURSELF BEING IN THE NEXT 1 TO 3 YEARS IF THIS PROBLEM IS NOT TAKEN CARE OF?

PLEASE BE SPECIFIC: ____

____

____

____

10. WHAT WOULD YOU BE DIFFERENT/BETTER WITHOUT THIS PROBLEM? PLEASE BE SPECIFIC: __________________________

____

____

____

11. WHAT DO YOU DESIRE MOST TO GET FROM WORKING WITH US?

____

____

____

____

12. WHAT WOULD THAT MEAN TO YOU? ____

____

____

____

CURRENT PAIN LEVELS FOR KNEE PAIN PATIENT

1. HOW WOULD YOU DESCRIBE YOUR AVERAGE KNEE PAIN OVER THE PAST WEEK?

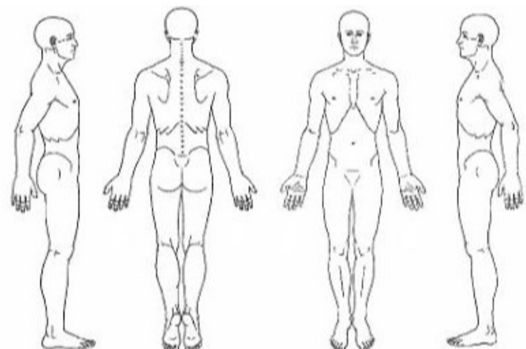
NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

2. PLEASE INDICATE WHAT YOU CONSIDER TO BE AN ACCEPTABLE LEVEL OF PAIN AFTER COMPLETION OF THE TREATMENT, IF YOU HAVE TO ACCEPT SOME PAIN?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

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



WALKING SCALE QUESTIONAIRE FOR KNEE PAIN PATIENTS

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 YOUR CONSULTATION.

IN THE PAST TWO WEEKS, HOW MUCH HAS YOUR KNEE…	NOT AT ALL	A LITTLE	MODERATELY	QUITE A BIT	EXTREMELY
LIMITED YOUR ABILITY TO WALK?	1	2	3	4	5
LIMITED YOU 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 STAND-ING 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? (HOLDIN ONTO FURNITURE, CANE, ETC)	1	2	3	4	5
MADE IT NECESSARY FOR YOU TO USE SUPPORT WHEN WALKING OUTDOORS (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

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

KNEE PAIN PROGRAM QUALIFICATION QUESTIONNAIRE

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS BY MARKING ONE ANSWER PER QUESTION.

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 6 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 (TYLENOL, ASPRIN, 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 PERSNAL 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

PREVIOUS HEALTH HISTORY

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND PERTINENT PERSONAL INFORMATION. THE DOCTOR RESERVES THE RIGHT TO DISCUSS THIS INFORMATION WITH MEDICAL AND ALLIED HEALTH PROFESSIONALS PER THE INFORMED CONSENT. COPIES BY YOUR VERBAL REQUEST.

NAME: ____ SIGNATURE: ____

PLEASE GIVE THE NAME, ADDRESS AND OFFICE PHONE NUMBER OF YOUR PRIMARY CARE PHYSICIAN.

NAME: ____ PHONE: ____

ADDRESS: ____

WHEN WERE YOU LAST SEEN THERE? ____

MAY WE SEND THEM UPDATES ON YOUR TREATMENT/CONDITION? ☐ YES ☐ NO

STATEMENT

A. I HEREB AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO EVALUATE MY CASE OR PROCESS ANY FU- TURE CLAIMS.

B. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS FROM TIRD 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.

C. 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: ___________________________________