The Livingston Clinic
Dr. Stuart Meyers, D.C.
5889 Whitmore Lake Rd, Suite 3 ~ Brighton, MI 48116
810-227-7799 ~ www.TheLivClinic.com

Name:_____ Date:_____

Knee Care Application

Nickname:_____ Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F

Address:_____

City:_____ State:_____ Zip:_____

Mobile Phone #:_____ Alternate Phone #: _____

Email Address: _____

Occupation (Current or Previous): _____ Retired: ☐ Yes ☐ No

Employer: _____

Current or Previous Work Type:

Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse/Partner/Parent/Other Trusted Adult: _____ _____

(Name) (Phone)

Marital Status: ☐ S ☐ M ☐ D ☐ W Number of Children: _____

In Case of Emergency: Contact Name: _____ Phone #: _____

How did you hear about our office? _____

What is your main health concern / condition today? _____

When did this begin? _____

What makes it worse? _____

What makes it better? _____

How would you describe your symptoms? *(Check all that apply)*

☐ Limping	☐ Stiff	☐ Swelling	☐ Stabbing	☐ Sharp	☐ Grinding
☐ Throbbing	☐ Ache	☐ Weakness	☐ Tiredness	☐ Electric Shocks	☐ Cold
☐ Burning	☐ Numbness	☐ Cramping	☐ Dead Feeling	☐ Stings	☐ Pins & Needles

Is this condition interfering with any of the following? *(Check all that apply)*

☐ Daily Activities ☐ Relationships ☐ Hobbies ☐ Exercise ☐ Standing ☐ Walking ☐ Lifting ☐ Sleep ☐ Work

Does your pain cause any other problems? _____

Frequency of your Pain:

☐ Constant (76–100%) ☐ Frequent (51–75%) ☐ Occasional (25–50%) ☐ Intermittent (24% or less)

On average what level would you rate your overall knee pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

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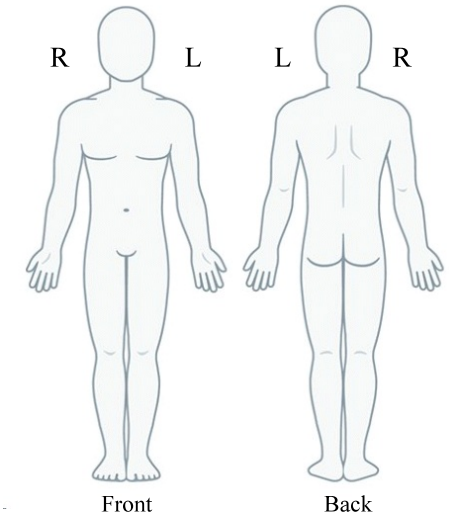
Name:_____ Date:_____

Please indicate on this drawing the area(s) where you are currently experiencing symptoms:



Has your knee pain interfered with daily activities (walking, going up / down stairs, prolonged standing, sit to stand) for at least 6 months? _____

Have you tried pain and / or anti-inflammatory medications (i.e., Tylenol, Aspirin, Aleve, Advil, Prescription Medications, Pain Creams, etc.) for at least 3 months without gaining long term relief from your symptoms? If yes, what have you tried?

_____

Have you tried physical therapy for the affected knee(s) without long-term relief from your symptoms?

_____

Have you used a knee brace without long-term relief of your symptoms? What type of knee brace?

_____

Have you tried Steroid / Cortisone Injection(s) to the knee without long-term relief?

☐ No ☐ Yes - How many? _____

Please list any / all prescription medications or vitamins / supplements you are currently taking (continue on back if you need more room or you may attach a list):

Name of Prescription Medication / Vitamin / Supplement	**Why Do You Take It?**

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Name:_____ Date:_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many cigarettes daily? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, please describe type & how often? _____

_____

Please list below any Back, Knee, or Leg surgeries you've had and the dates: _____

_____

Have you had an MRI performed on your Back/Legs/Knees/Feet? ☐ No ☐ Yes, when? _____

Has your doctor ever drained excess fluid from your affected knee(s)? ☐ No ☐ Yes, when? _____

COMPREHENSIVE HEALTH HISTORY

☐ Knee Surgery(s)	☐ Sciatica	☐ High Cholesterol	☐ Leg Fracture
☐ Joint Replacement	☐ Leg or Foot Pain / Numbness	☐ Foot Surgery(s)	☐ Gout
☐ Neck Pain	☐ Herniated/Bulging Disc	☐ Vascular Leg Problems	☐ Vascular Surgery(s)
☐ Spinal Arthritis	☐ Hand Pain/Numbness	☐ Neuropathy	☐ Stroke
☐ Mid Back Pain	☐ Kidney Disease	☐ High Blood Pressure	☐ Headaches
☐ Low Back Pain	☐ Heart Attack	☐ Diabetes - Type I or II	
☐ Spinal Surgery(s)	☐ Cancer	☐ Other:	

Name of your Primary Care Physician: _____

Office / Clinic: _____

May we contact them with updates regarding your treatment? ☐ No ☐ Yes: _____
(Phone Number)

I hereby authorize the release of any medical information necessary to evaluate my case to:

_____.

The Livingston Clinic will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patient's responsibility to contact their own insurance provider.

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:** _____

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Knee Function Questionnaire

These questions ask about limitations you may be experiencing due to your knee pain during the last 10 days. For each question, please circle only **ONE** answer that best describes your degree of limitation.

In the past 10 days, how has your knee pain affected…	Able to Complete	Able to Complete with Effort	Unable to Complete Some Days	Unable to Complete Most Days	Unable to Complete Task
Your ability to walk without assistance (cane or walker)?					
Your ability to walk without a limp?					
The distance you are able to walk?					
Your ability to use stairs (up or down)?					
Your ability to fall asleep or stay asleep through the night?					
Your balance or stability when walking or standing? (falling or unsure footing)					
Your ability to get up from a seated position?					
Your ability to complete daily activities around your home? (Laundry, dishes, vacuuming, cooking, etc.)					
Your ability to complete errands? (Grocery shopping, doctors' appointments, etc.)					
Your ability to get in and out of a vehicle?					

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Functional Goals Survey

Please answer these questions the best you can so we can help you get better.

1. What is the ***main reason*** you have come to see us today? _____
2. How many doctors have you seen for this condition? _____
3. What medications/supplements/therapies/treatments did they prescribe/recommend for you?
4. Has what you've done to date for your condition helped?
   ☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent
5. What are 3 - 5 activities you can no longer do or are struggling to do because of this condition? Please be specific.

1. _____
2. _____
3. _____
4. _____
5. _____

6. What is your honest vision of your life in the next few years if this problem continues to progress?
7. What would be different and/or better without this problem? Please be specific.
8. What is your biggest fear in regards to the progression of this condition?
9. What would be and/or mean success to you in our office?

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CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, including exercise, traction, use of vibration platforms, laser and LED Infra red light, hyperbaric oxygen, Shockwave, and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Stuart Meyers, D.C. and/or other doctors of chiropractic and staff who now or in the future work at The Livingston Clinic.

I have had an opportunity to discuss with Dr. Meyers and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, and possibly other unforseen complications. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to treatment and x-rays. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To the best of my knowledge I am ***NOT*** pregnant and Dr. Meyers and his staff has my permission to x-ray me for diagnostic interpretation.

By signing this authorization, I am also agreeing to have texts and/or emails sent to the number or email I have provided, from The Livingston Clinic and its employees.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctor's recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

_____ _____

Patient's Signature or of person acting on patient's behalf (Relationship) **Date Signed**

_____ _____

Witness's Signature **Date Signed**

Clinic Name: The Livingston Clinic **Clinic Phone Number:** (810) 227-7799
Doctor Information: Dr. Stuart Meyers, D.C.

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PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

I understand that The Livingston Clinic's "Patient Privacy and Information Security Policy" in its full form is available to me upon request and that I have a right to review the "Patient Privacy and Information Security Policy" prior to signing this document.

The "Patient Privacy and Information Security Policy" describes the types of uses and disclosures of my protected health information and the policies and procedures of confidentiality that will occur in my treatment, payment of my bills or in the performance of healthcare operations of The Livingston Clinic. This "Patient Privacy and Information Security Policy" also describes my rights and The Livingston Clinic's duties with respect to my protected health information and patient confidentiality.

The Livingston Clinic reserves the right to change the privacy practices that are described in the Patient Privacy and Information Security Policy". I may obtain a copy of the revised notice by calling the office and requesting a copy be sent to me by mail or by asking for one at the time of my next appointment.

I give permission for the doctor(s) and/or staff to discuss my

□ Care / Condition / Treatment □ Financial Statements with the following persons.

Name	**Relationship**
_____	_____
_____	_____

I understand the above permissions will remain in effect until such time as they are revoked in writing. A new authorization, when completed, will replace any older authorizations.

_____ _____

Patient's Signature **Date Signed**

Or Signature of person acting on patient's behalf (relationship)

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OFFICE FINANCIAL POLICY

We welcome you and your family to our office. We take pride in providing quality chiropractic care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY

Payment is due the day service is provided.

- While we work with all insurance companies, our office may not be "in network" with your insurance. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to determine coverage status. However, even in network coverage is not a guarantee of coverage.

- Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records. All insurance claims are filed weekly on Thursday or Friday.

- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services and will be your responsibility.

- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

MY FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services not covered by Insurance or by Medicare. I am also responsible for all applicable annual deductibles or copayments.

CANCELLATION POLICY

If for any reason you cannot make your pre-scheduled appointment time we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment more than three times an administrative fee of $25.00 will be charged to your account*. No further treatments will be administered until this fee is paid.

I have read and understand the Financial Office Policy and agree to abide by these terms.

X _____ _____

Patient's Signature or person acting on patient's behalf (Relationship) **Date Signed**