SOUTHWEST
KNEE & SHOULDER CENTER
WHEN SURGERY IS NOT AN OPTION

Patient Qualification Intake Form

Welcome to Southwest Knee & Shoulder Center. In order to accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date _____

Name _____ Sex M F Age _____ Birthday _____

Address

_____

City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation_____

Length of Employ_____

How Did You Hear About Southwest Knee & Shoulder Center? _____

What Is Your Main Problem/Symptom Prompting Your Request for a Consultation With The Doctor?

_____

Would You Consider This Problem (circle one)..

- MINIMAL (Annoying but causing NO limitations)
- SLIGHT (Tolerable but causing a little limitation)
- MODERATE (Sometimes tolerable but definitely causing limitations)
- SEVERE (Causing Significant limitations)
- EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a specialist, you are in fact the person who knows more about your problem than anyone else. In your own words and in your own opinion what do you think the real problem is?

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2. What are your hoping happens today as a result of your consultation with the Doctor?

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3. Since your problem became this severe what three things has it caused you to miss the most?

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4. How long have you been like this?

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5. How has your life changed since your condition became a problem?

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6. What activities are you limited in?

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7. What kinds of treatments have you received?

Physical Therapy: How Long _____ When(approx) _____

Medication: _____ When(approx) _____

Surgery: Type_____ When(approx) _____

Other_____

8. Did any of these treatments work? If so which one(s)? For how long?

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9. Is there anything you can do that makes it feel better?

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10. What activities/movements are guaranteed to make it worse?

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11. Please describe the quality of the pain. (sharp, dull, achy, shooting, stabbing, numb, tingling)

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12. Is it worse in the morning or is it worse as the day progresses?

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13. If you cannot find a solution to this problem what do you think will happen to you?

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14. Describe what will be different in your life if you can get better.

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15. When is the VERY FIRST time you recall having this problem?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1._____ How Long Have You Had This?_____

2._____ How Long Have You Had This?_____

3._____ How Long Have You Had This?_____

4._____ How Long Have You Had This?_____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No How much time _____?

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Chores Have Been Limited?

_____

Have You Lost Any Time From Your Family? Yes No

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports) Yes No

How Much Time and What Leisure Activities Have Been Limited?

_____

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?

_____

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

The HIGHEST your pain gets WITHOUT medication _____
The LOWEST your pain gets WITHOUT medication _____
The HIGHEST your pain gets WITH medication _____
The LOWEST your pain gets WITH medication _____
List ANY surgeries that you have had and the corresponding dates.

Signature: _____ Date: _____

Thank You.
You will be seen shortly with our doctor.
In the meantime, if there is anything that we can do to make you more comfortable,
Please don't hesitate to ask.