

CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____ Date of Birth _____

Name: _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age _____

Male

Female

email address _____

Marital Status:

Married

Single

Divorced

Separated

Other

Mother's Name if minor _____ Father's Name if minor _____

Name of Individual to contact in case of emergency: _____ Phone : _____

Number of Children: _____ Names and ages of children: _____

Your Occupation: _____ Your Employer _____

Employer's Address _____ Employer's Number (____) _____

Who is your Primary Care Physician? _____

Referred to this office by: TV Healthbeat Mailing Star News Location Internet

Google Natural Awakening

Health & Medical Magazine

Dr. Graf's Book

Friend - Name? _____ MD - Name? _____

Other _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

Have you ever had a metal implant? Yes No

Ever been gunshot? Yes No

Do you have a Pacemaker? Yes No

Do you have a Defibrillator? Yes No

What type of care are you looking for?

Temporary Relief

Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. _____

2. _____

3. _____

4. _____

THIS PROBLEM IS: RAPIDLY IMPROVING
WORSENING

SLOWLY IMPROVING

GRADUALLY

FLUCTUATES BUT GETTING BETTER

REMAINS THE SAME

RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE Morning

Afternoon

Evening

All the time

APPROXIMATELY WHEN DID YOU START HAVING KNEE PAIN? _____

SYMPTOMS DEVELOPED FROM: Job injury Sports Injury Normal Wear & Tear Other

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Which Knee do you experience pain in? Right Left Both
2. Do you experience Knee Pain at rest? No Yes
3. Have you had x-ray/MRI confirming Knee Osteoarthritis (OA)? No Yes Unsure
4. Has your Knee Pain interfered with activities in the last six months? No Yes, please explain:

5. Do you have morning Knee stiffness? No Yes
6. Do you experience a grinding sensation with Knee movement? No Yes
7. Have you tried taking medication for your Knee Pain? No Yes

8. Have you tried physical therapy for your Knee Pain? No Yes
9. Have you tried a Knee Brace without long-term benefit? No Yes
10. Has your doctor ever drained fluid from the affected Knee? No Yes
11. Have you tried an injection into the affected Knee? No Yes

PLEASE CIRCLE YOUR LEVEL OF KNEE PAIN ON THE SCALE BELOW.

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

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Doctors Jason Graf, Aaron Richardet, Nikki Bailey and appointed staff to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature(STAFF) _____ Date _____