

## Conservative Treatment History Form (Joints)

There is significant value in conservative treatment. It is also important to document and for your provider to know your recent efforts before establishing further tests and or treatment.

The information in this form will capture conservative treatment history in the event an **intervention on your joints** needs to be requested. For other procedures, a different form might be needed.

**Please print clearly. Processing may be delayed if information submitted is illegible or incomplete.**

Today's Date:	Patient:	Date of Birth:
<b>Think about why you are seeing your provider today. Have you had these symptoms for six months or more?</b>		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If no to the above, how long have you had these symptoms?		
<b>Have you tried any of the following treatments?</b>		
Rest / changes or limiting your activity?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Weight reduction?	<input type="checkbox"/> YES IF YES, HOW MANY POUNDS _____ <input type="checkbox"/> NO	
Walking and or balancing aid?	<input type="checkbox"/> CANE <input type="checkbox"/> CRUTCHES <input type="checkbox"/> WALKER	
Heat or ice?	<input type="checkbox"/> HEAT <input type="checkbox"/> ICE <input type="checkbox"/> BOTH	
Knee brace?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Physical Therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes to physical therapy, please complete this section.		
What was the month and year you started? _____ What was the month and year you had your last session? _____		
Physician recommended home exercises for this problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes to physician recommended home exercises, please complete this section.		
What was the month and year you started? _____ What was the month and year you had your last session? _____		
Medications for this problem like over the counter anti-inflammatory or pain medications (ibuprofen, Tylenol) or narcotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	If yes, have you been taking them for 3 or more months? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Injection in the joint (Cortisone or Viscosupplement)?	<input type="checkbox"/> YES <input type="checkbox"/> NO Date of injection(s)? _____	
<b>Signatures</b>		
This completed, signed form will be part of the patient's medical record. When history of conservative treatment is required, this form or all information requested herein, should be supplied.		
Patient	Provider	