KNEE PAIN EVALUATION FORM

Patient Last Name: ____________________ First Name _____________ M.I. _______ Date: _____________

Please answer the following questions as they pertain to your knee

Which knee? R L If injured, date of injury: _____________ Occupation: ___________________

Is this injury due to an accident? Yes No **On the job**? Yes No **Motor vehicle**? Yes No

Are you currently out of work or on limited duty due to this injury? No Yes How long? ____________

If not injured, date of onset of symptoms: _________________ Duration of symptoms: ________________

How far can you walk prior to pain? ____

Do you avoid physical activity such as long distances, shopping, going up stairs? Yes No

Do you have a regular exercise program? Yes No

What is your amount of pain at rest? Least = 1 2 3 4 5 6 7 8 9 10 = Max

Pain during or immediately after activity? Least = 1 2 3 4 5 6 7 8 9 10 = Max

Do you consider your symptoms Annoying Inconvenient Restricting Disabling

Past history of knee problems? ____

Any prior knee surgeries? ________ Which knee R L Procedure____________________________

When __________________ Where _________________ Doctor _____________________________

Have you seen another doctor for this injury? ________________ Doctor _____________________________

Is this appointment for a second opinion? ____

Are you taking Vitamin D? No Yes How much? ________

Please write a brief description of how your injury or symptoms happened: ______________________________

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Please indicate in the boxes that apply √

Do you have?	**Which knee**		**Frequency**							
	R	L	With activity		Daily		Weekly		Rarely	
Locking			Yes	No	Yes	No	Yes	No	Yes	No
Giving way			Yes	No	Yes	No	Yes	No	Yes	No
Catching			Yes	No	Yes	No	Yes	No	Yes	No
Swelling			Yes	No	Yes	No	Yes	No	Yes	No
Pain at night			Yes	No	Yes	No	Yes	No	Yes	No
Morning stiffness			Yes	No	Yes	No	Yes	No	Yes	No
Clicking			Yes	No	Yes	No	Yes	No	Yes	No
Popping			Yes	No	Yes	No	Yes	No	Yes	No
Grinding			Yes	No	Yes	No	Yes	No	Yes	No
Difficulty w/stairs			Yes	No	Yes	No	Yes	No	Yes	No
Uneven terrain			Yes	No	Yes	No	Yes	No	Yes	No
Running			Yes	No	Yes	No	Yes	No	Yes	No
Kneeling			Yes	No	Yes	No	Yes	No	Yes	No

What previous treatments have you tried?	**Yes**	**No**
Chondroitin/glucosamine or other cartilage supplements		
Physical therapy		
Steroid injections		
Synvisc injections		
Other medications: celebrex, aleve, Tylenol, etc		
Ice		
Bracing		
Shoe inserts		
Activity modification		
Cane, walking stick		

Patient Signature: ____ Date: ___________________________