

KNEE PAIN EVALUATION FORM

Name: _____ Chart # _____ 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 _____ Procedure _____

When _____ Where _____ Doctor _____

Have you seen another doctor for this injury? _____ Doctor _____

Is this appointment for a second opinion? _____

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

Please indicate in the boxes that apply \checkmark

Do you have?	Which knee		Frequency			
	R	L	With activity	Daily	Weekly	Rarely
Locking						
Giving way						
Catching						
Swelling						
Pain at night						
Morning stiffness						
Clicking						
Popping						
Grinding						
Difficulty w/stairs						
Uneven terrain						
Running						
Kneeling						

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: _____