KNEE PATIENT EVALUATION FORM

PLEASE ANSWER ALL QUESTIONS COMPLETELY (BLUE OR BLACK INK ONLY)

NAME: ___________________________ CHART # __________________

AGE: ___________________ SEX: ______________ WHICH KNEE: __________

HOW LONG HAVE YOU HAD SYMPTOMS: ______________ TODAY’S DATE: __________

DATE THIS PROBLEM BEGAN: __________________________________________

1. MY MAJOR COMPLAINT IS (check all that apply)

   __________ pain  __________ dull ache  __________ loss of motion
   __________ swelling  __________ grinding
   __________ giving out  __________ locking
   __________ other (please explain) ___________________________________________________________________________________

2. DID THIS PROBLEM START: (check all that apply)

   __________ gradually  __________ vehicle accident
   __________ suddenly  __________ don’t know
   __________ while playing sports —which sport __________________________________________________________________________
   __________ while at work

   IF YOU HAVE BEEN EXPERIENCING PAIN, PLEASE ANSWER THIS SECTION.
   IF NOT, PLEASE GO TO QUESTION 8.

3. THE PRIMARY LOCATION OF PAIN IS: (check those that apply)

   __________ knee cap  __________ throughout the knee  __________ outer side
   __________ back  __________ inner side  __________ deep inside

4. WHEN DOES THE AFFECTED KNEE HURT? (please check one)

   __________ infrequently  __________ constantly
   __________ when active

4A. DOES THE AFFECTED KNEE HURT WHEN YOU ARE RESTING?

   __________ yes  __________ no

5. DOES THE PAIN IN THE AFFECTED KNEE OCCUR AT NIGHT?

   __________ yes  __________ no

5A. WHEN THIS PAIN OCCURS, DOES IT AWAKEN YOU?

   __________ yes  __________ no

6. WHEN IS THE PAIN MADE WORSE? (please check those that apply)

   __________ sitting  __________ standing  __________ walking  __________ climbing stairs
   __________ getting up  __________ running  __________ during physical exercise

7. THE PAIN IS RELIEVED BY: (check those that apply)

   __________ nothing  __________ rest  __________ moving the knee
   __________ heat therapy  __________ activity
   __________ cold therapy
   __________ medicine—if so, what kind? ____________________________________________________________________________________________
8. IS THE AFFECTED KNEE EVER SWOLLEN? (check those that apply)
   never ___________________________ only after exercise or use
   infrequently ___________________________ only at the time of the original injury, but not since then
   constantly

9. ARE THERE ANY GRATING OR GRINDING NOISES OR SENSATIONS IN THE JOINT?
   none
   when getting up from chair
   when walking
   when climbing stairs
   when descending stairs
   when I do deep knee bends

10. WHEN DOES YOUR KNEE LOCK (GET STUCK)?
    never
    frequently or occasionally
    continually

11. WHEN KNEE GIVES OUT OR BUCKLES IT FEELS LIKE: (check those that apply)
    this does not apply
    kneecap shifts
    entire knee shifts
    something inside the knee shifts

12. WHAT IS THE RANGE OF MOTION IN YOUR AFFECTED KNEE?
    same as ever
    unable to fully straighten the joint
    unable to fully bend or flex the joint

13. MOBILITY OF THE JOINT:
    able to walk normally
    walk with a limp

14. WHAT ACTIVITIES ARE YOU UNABLE TO DO? (please check those that apply)
    walk-how far?
    ½ block
    less than ½ mile
    1 block
    greater than ½ mile
    climb
    jump
    not affected
    squat
    run

15. ARE YOU USING WALKING AIDS?
    none
    cane
    crutches
    wheelchair
    brace
    walker

16. WERE YOU TREATED BY A PHYSICIAN FOR THIS PROBLEM? YES ________ NO
    DOCTOR:
    ADDRESS:
    DIAGNOSIS:
    TREATMENT:
    TYPE OF DOCTOR:

17. WERE YOU TREATED AT AN EMERGENCY ROOM FOR THIS PROBLEM? YES ________ NO
    HOSPITAL:
    ADDRESS:
18. DID YOU HAVE XRAYS TAKE FOR THIS PROBLEM?  
   
   ________ YES ________ NO  
   
   DATE  LOCATION  RESULTS  
   
   ________  __________________________  __________________________  
   
   ________  __________________________  __________________________  

19. DID YOU HAVE AN ARTHROGRAM? (dye test)  
   
   ________ YES ________ NO  
   
   DATE  LOCATION  RESULTS  
   
   ________  __________________________  __________________________  
   
   ________  __________________________  __________________________  

20. DID YOU HAVE AN ARTHROSCOPY OR ARTHROSCOPIC SURGERY PERFORMED ON THE AFFECTED KNEE? (looking into the joint)  
   If yes, please list below:  
   
   ________ YES ________ NO  
   
   DATE  LOCATION  RESULTS  
   
   ________  __________________________  __________________________  
   
   ________  __________________________  __________________________  

21. DID YOU HAVE OPEN SURGERY ON THE KNEE JOINT?  
   If yes, please list below:  
   
   ________ YES ________ NO  
   
   DATE  DOCTOR  TYPE  RESULT  COMPLICATION  
   
   ________  __________________________  ________  ________  ________  
   
   ________  __________________________  ________  ________  ________  

22. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?  
   If yes, please check below:  
   
   ________ heart disease  ________ high blood pressure  
   
   ________ lung disease  ________ diabetes  
   
   ________ rheumatoid arthritis  ________ other arthritis  
   
   ________ inherited disease  ________ gout  
   
   ________ stomach ulcer  ________ bleeding tendency  
   
   ________ circulation problems  ________ cancer  
   
   ________ other (describe)  

23. HAVE YOU BEEN UNDER A DOCTORS CARE IN THE LAST TWO YEARS?  
   
   ________ YES ________ NO  
   
   If yes, please list below:  
   
   DOCTOR:  __________________________ ADDRESS:  __________________________  
   
   REASON:  __________________________  

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24. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

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<th>MEDICATION</th>
<th>DOSAGE</th>
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HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS WITHIN THE PAST SIX MONTHS?

25. 

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- Cortisone pills or shots
- High blood pressure pills
- Water pills
- Heart medicine
- Insulin

26. PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION:

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<th>ALLERGY</th>
<th>REACTION</th>
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27. PLEASE LIST ANY MAJOR SURGERIES YOU HAVE HAD ALONG WITH ANY COMPLICATIONS THAT MAY HAVE OCCURRED:

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<tr>
<th>SURGERY</th>
<th>COMPLICATIONS</th>
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28. PLEASE RATE YOUR OVERALL LEVEL OF PHYSICAL HEALTH:

- excellent
- good
- poor
- very good
- fair

HEIGHT: __________________________________________ WEIGHT: ________________________

RIGHT HANDED __________ LEFT HANDED __________ BOTH __________

DO YOU SMOKE? ________ YES ________ NO

DO YOU DRINK ALCOHOL?

- YES
- NO

- DAILY
- OCCASIONALLY
- RARELY

29. WHO REFERRED YOU TO US FOR THIS EVALUATION AND CARE?

- physician
- trainer
- former patient
- found the office in the yellow pages
- coach
- word of mouth (includes other patients)
DATE: ________________________________

NAME: ________________________________

DESCRIBE BRIEF HISTORY OF HOW CURRENT INJURY OCCURRED:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HAVE YOU HAD A PREVIOUS PROBLEM IN THIS AREA? IF SO, PLEASE DESCRIBE:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HAVE YOU LOST TIME FROM WORK BECAUSE OF THIS INJURY?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

BRIEFLY DESCRIBE YOUR JOB ACTIVITIES: (LIFTING, PUSHING, PULLING, etc.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HAVE YOU EVER HAD:

YES ________ NO ________ BROKEN BONES (IF SO, WHICH ONES AND WHEN)

YES ________ NO ________ HEAD INJURIES-WHEN __________________________

YES ________ NO ________ NECK INJURIES-WHEN __________________________

YES ________ NO ________ BACK INJURIES-WHEN __________________________

HAS ANY MEMBER OF YOU IMMEDIATE FAMILY EVER HAD:

YES ________ NO ________ CANCER

YES ________ NO ________ HEART DISEASE

YES ________ NO ________ LUNG DISEASE, TB, etc.

YES ________ NO ________ DIABETES

YES ________ NO ________ ARE YOU PREGNANT?

PHYSICIAN ONLY

Reviewed: ________________

Date: ________________

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