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
_____ infrequently
_____ constantly
_____ only after exercise or use
_____ only at the time of the original injury, but not since then

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
_____ at first, not now
_____ continually

11. WHEN KNEE GIVES OUT OR BUCKLES IT FEELS LIKE: (check those that apply)

_____ this does not apply
_____ entire knee shifts
_____ kneecap 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
_____ 1 block
_____ less than ½ mile
_____ greater than ½ mile
_____ climb
_____ jump
_____ squat
_____ not affected
_____ 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? _____ YES _____ NO

If yes, please list below:

DATE	DOCTOR	TYPE	RESULT	COMPLICATION

22. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS? _____ YES _____ NO

If yes, please check below:

_____ heart disease
_____ lung disease
_____ rheumatoid arthritis
_____ inherited disease
_____ stomach ulcer
_____ circulation problems
_____ other (describe)

_____ high blood pressure
_____ diabetes
_____ other arthritis
_____ gout
_____ bleeding tendency
_____ cancer

23. HAVE YOU BEEN UNDER A DOCTORS CARE IN THE LAST TWO YEARS?

_____ YES _____ NO

If yes, please list below:

DOCTOR: _____ ADDRESS: _____

REASON: _____

24. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	DOSAGE

25. HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS WITHIN THE PAST SIX MONTHS?

	YES	NO
Cortisone pills or shots		
High blood pressure pills		
Water pills		
Heart medicine		
Insulin		

26. PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION:

ALLERGY	REACTION

27. PLEASE LIST ANY MAJOR SURGERIES YOU HAVE HAD ALONG WITH ANY COMPLICATIONS THAT MAY HAVE OCCURRED:

SURGERY	COMPLICATIONS

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 REFFERED 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: _____