Lower Extremity Symptom and Pain Questionnaire

Last Name: ______________________ First Name: ____________________ Middle Initial: ____________

Date of Birth: __________ Age: ________ Occupation: ______________________________

Reason for visit: ____

Which side: ☐ Right ☐ Left ☐ Both Approximate date of onset: ______________________

Please indicate which apply: ☐ Sports injury ☐ Work injury ☐ Motor vehicle accident

☐Other (please describe): ______________________________________

Describe how you injured your knee and/or lower extremity: ______________________________

Are you: ☐ Right handed ☐ Left handed

Rate your pain discomfort (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

Major complaint: ☐ Pain ☐ Swelling ☐ Slipping out ☐ Locking ☐ Loss of motion ☐ Grinding ☐ Buckling ☐ Instability ☐ Popping

☐ Other ____

Pain is: ☐ Constant ☐ Frequent ☐ Occasional ☐ Sharp ☐ Throbbing ☐ Burning ☐ Electric shot ☒ Nothing

Location of pain: ☐ Front ☐ Back ☐ Knee cap ☐ Inner side ☐ Outer side ☐ All over

☐Other (please describe): ______________________________________

Pain associated with: ☐ Rest ☐ Prolonged sitting ☐ Sports ☐ Rising from chair ☐ Weight bearing ☐ Stairs ☐ Kneeling ☐ Squatting

☐ Other (please describe): ______________________________________

Pain relieved by: ☐ Rest ☐ Activity ☐ Heat ☐ Ice ☐ Other (please describe): ______________________

☐ Medication (if so, which): ______________________________________

Distance you can walk without pain: ☐ Unlimited ☐ Short distances (how many blocks?): _______

☐ How many aisles in supermarket? _______ ☐ House bound

Treatment to date (check all that apply):

☐ Medication (list): ____
☐ Cortisone injection
☐ MRI/X-ray (when & where): ______________________________________
☐ Physical therapy (if so how long & what result): ______________________________
☐ Surgery (please describe): ______________________ Surgeon: ______________ Date: __________
☐Other: ____

Do you utilize any assisted devices? ☐ No ☐ Yes If yes, which: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other: ________

Do you participate in sports? If so, which: ______________________________________

Patient signature: ______________________________ **Date:** ____________________