KNEE PATIENT EVALUATION FORM

PLEASE ANSWER ALL QUESTIONS COMPLETELY

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)

_____ kneecap _____ 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
_____ at the time of the original injury, but not since then

9. ARE THERE ANY GRATING OR GRINDING NOISES OR SENSATIONS IN THE JOINT? (please check those that apply)

_____ none
_____ when getting up from a 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

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

_____ does not buckle
_____ entire knee shifts
_____ kneecap shifts
_____ something inside the knee shifts

13. 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

14. MOBILITY OF THE JOINT:

_____ able to walk normally
_____ walk with a limp

16. WHAT ACTIVITIES ARE YOU UNABLE TO DO? (please check those that apply)

_____ walk - how far?
_____ 1/2 block
_____ 1 block
_____ less than 1/2 mile
_____ greater than 1/2 mile

_____ climb
_____ squat
_____ run
_____ jump
_____ not affected

17. ARE YOU USING ANY WALKING AIDS?

_____ none
_____ wheelchair
_____ cane
_____ brace
_____ crutches
_____ walker

18. HAVE YOU SEEN A PHYSICIAN FOR THIS PROBLEM? _____ YES _____ NO

DOCTOR: _____

ADDRESS: _____

DIAGNOSIS: _____

TREATMENT: _____

TYPE OF DOCTOR: _____

20. WERE YOU TREATED AT AN EMERGENCY ROOM FOR THIS PROBLEM?
_____ YES _____ NO

HOSPITAL _____

ADDRESS _____

21. DID YOU HAVE X-RAYS TAKEN FOR THIS PROBLEM? _____ YES _____ NO
If yes, please list below:

DATE	LOCATION	RESULTS
_____	_____	_____
_____	_____	_____

22. DID YOU HAVE AN ARTHROGRAM? (dye test)? _____ YES _____ NO
If yes, please list below:

DATE	LOCATION	RESULTS
_____	_____	_____
_____	_____	_____

23. DID YOU HAVE AN ARTHROSCOPY OR ARTHROSCOPIC SURGERY PERFORMED ON THE AFFECTED KNEE? (looking into the joint) _____ YES _____ NO
If yes, please list below:

DATE	LOCATION	RESULTS
_____	_____	_____
_____	_____	_____

24. DID YOU HAVE OPEN SURGERY ON THE KNEE JOINT? _____ YES _____ NO
If yes, please list below:

DATE	DOCTOR	TYPE	RESULT	COMPLICATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

25. 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

26. HAVE YOU BEEN UNDER A DOCTORS CARE IN THE LAST TWO YEARS?
_____ YES _____ NO
If yes, please list below:

DOCTOR: _____ ADDRESS: _____

REASON _____

27. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	DOSAGE
_____	_____
_____	_____

28. 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	_____	_____

29. PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION:

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

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

SURGERY	COMPLICATIONS
_____	_____
_____	_____
_____	_____

31. 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

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

_____ physician
_____ former patient
_____ coach
_____ trainer
_____ found the office in the yellow pages
_____ 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 YOUR 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?