

## 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                       only after exercise or use  
 infrequently               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?  
(please check those that apply)
- none                                       when climbing stairs  
 when getting up from a chair       when descending stairs  
 when walking                           when I do deep knee bends
10. WHEN DOES YOUR KNEE LOCK (GET STUCK)?
- never                                       at first, not now  
 frequently or occasionally       continually
12. WHEN KNEE GIVES OUT OR BUCKLES IT FEELS LIKE: (check those that apply)
- does not buckle                       kneecap shifts  
 entire knee 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     less than 1/2 mile  
                                       1 block        greater than 1/2 mile
- climb                                       jump  
 squat                                       not affected  
 run
17. ARE YOU USING ANY WALKING AIDS?
- none                                       cane               crutches  
 wheelchair                           brace               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	_____ high blood pressure
_____ lung disease	_____ diabetes
_____ rheumatoid arthritis	_____ other arthritis
_____ inherited disease	_____ gout
_____ stomach ulcer	_____ bleeding tendency
_____ circulation problems	_____ cancer
_____ other (describe) _____	

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	_____ 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 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?