Name:
DOB:
Chart:
Age:
Date:

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KNEE PAIN EVALUATION FORM

Name _____ **Chart #** _____ **Today's Date** _____
Which knee? ☐ L ☐ R **If injured, date of injury:** _____ **Occupation:** _____
Is this injury due to an accident? ☐ Yes ☐ No **On the job?** ☐ Yes ☐ No **Motor Vehicle?** ☐ Yes ☐ No
Are you currently out of work or on limited duty due to this injury? ☐ Yes ☐ No **How long?** _____
If not injured, date of onset of symptoms: _____ **Duration of symptoms:** _____
How far could you walk prior to pain? _____
Do you avoid physical activity such as long distances, shopping, going up stairs? ☐ Yes ☐ No
Do you have a regular exercise program? ☐ Yes ☐ No
What is your amount of pain at rest? Least = 1 1 2 3 4 5 6 7 8 9 10 Most = 10
Do you have pain during or immediately after activity? Least = 1 1 2 3 4 5 6 7 8 9 10 Most = 10
Do you consider your pain: ☐ Annoying ☐ Inconvenient ☐ Restricting ☐ Disabling
Past history of knee problems? _____
Any prior knee surgeries? ☐ Yes ☐ No **Which knee?** ☐ L ☐ R **Procedure:** _____
When? _____ **Where?** _____ **Doctor:** _____
Have you seen another doctor for this injury? ☐ Yes ☐ No **Doctor:** _____
Is this appointment for a second opinion? ☐ Yes ☐ No
Please write a brief description of how your injury or symptoms happened: _____

Please indicate in the boxes that apply with a √

Do you have?	**Which knee?** L	R	With activity	**Frequency** Weekly	Rarely
Locking	☐	☐	☐	☐	☐
Giving way	☐	☐	☐	☐	☐
Catching	☐	☐	☐	☐	☐
Swelling	☐	☐	☐	☐	☐
Pain at night	☐	☐	☐	☐	☐
Morning stiffness	☐	☐	☐	☐	☐
Clicking	☐	☐	☐	☐	☐
Popping	☐	☐	☐	☐	☐
Grinding	☐	☐	☐	☐	☐
Difficulty w/stairs	☐	☐	☐	☐	☐
Uneven terrain	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐

What previous treatments have you tried?

Chondroitin/glucosamine or other cartilage supplements _____	☐ Yes	☐ No
Physical therapy _____	☐ Yes	☐ No
Steroid injections _____	☐ Yes	☐ No
Hyaluronic Injections (Hyalgan, Supartz, Synvisc, Etc) _____	☐ Yes	☐ No
Other medications (Celebrex, Aleve, Tylenol, etc. _____	☐ Yes	☐ No
Ice _____	☐ Yes	☐ No
Bracing _____	☐ Yes	☐ No
Shoe inserts _____	☐ Yes	☐ No
Activity modification _____	☐ Yes	☐ No
Cane or walking stick _____	☐ Yes	☐ No

Patient Signature: _____ Date _____