



NAME: _____ AGE: _____ SEX: M/F DATE: __/__/__ Occupation: _____

Affected Knee (please circle):	Right	Left	if both, is one worse? Yes No
Do you have pain?	Yes	No	If yes, for how long?: _____
Did you have a specific injury?	Yes	No	If yes, when? Date: _____
Have you had recurrent injuries?	Yes	No	If yes, how many?: _____
Did you injure your knee playing sports?	Yes	No	If yes, sport?: _____
Does or has your knee given out?	Yes	No	If yes, number of times: _____
Does your knee swell?	Yes	No	How often? _____
On a scale of 1-10, how severe is your pain at worst? _____			

Please briefly describe the injury and activity at the time of the original injury and current symptoms:

What are your most common physical activities?

Do you have pain going up or down stairs, or squatting?	Yes	No	Right	Left
Where do you have pain in the knee-please circle (front, back, inside, outside, all over)				
Does your knee feel stiff after sitting?	Yes	No		
Does your knee lock?	Yes	No		
Does your knee give out or feel unstable?	Yes	No		
Does your knee click or pop?	Yes	No		
Do you have pain with twisting type activities?	Yes	No		
What medications are you taking for your pain? (ex: Vicodin, Ibruprofen, Aleve)				
Have the medications helped?	Yes	No		
Have you tried icing your knee?	Yes	No		
Have you done physical therapy for your knee?	Yes	No		
Have you tried any type of brace?	Yes	No		
Has your knee been injected?	Yes	No		
Did the injections help?	Yes	No	With what/when? _____	
Have you had knee surgery on your right or left knee?	Yes	No	If so, for how long? _____	
If yes, please describe what surgery was performed and when: _____				

Do you walk with: (check one) No Crutches or Cane Crutches Cane Walker
 How far can you walk? Unlimited Less than 1 block 1-5 blocks 5-10 blocks Unable

Do you have any numbness or tingling? Yes No If yes, where: _____