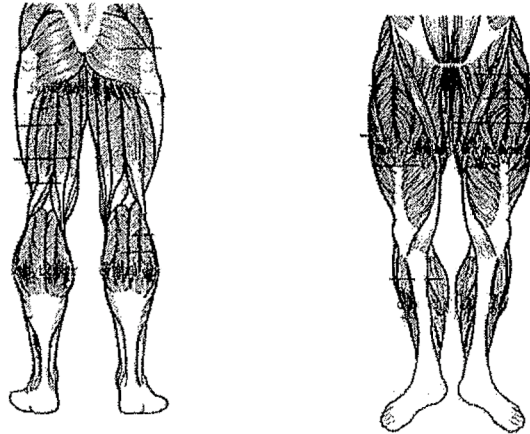


Knee Symptom Intake Form

Name: _____

Date: _____

Pain : Please draw the location of your pain:



My pain is (circle which applies): Sharp / Dull / Stabbing / Aching / Burning

Constant / Intermittent / Quick to come and go / Awakens me from my sleep.

Present with: Activity / Rest

The following activities aggravate my pain (circle which applies):

Walking uphill or stairs. / Walking downhill or stairs / Twisting

Kneeling / Getting up out of a chair / Getting out of bed in the morning

Running / Jumping / Bending my knee / Straightening my knee

Does your pain radiate (spread or travel)? Yes / No

If yes, where does it go? _____

Swelling:

Did your knee swell within 4 to 6 hours of an injury? Yes / No

Did your knee swell within 24 hours of an injury? Yes / No

Does your knee swell after activity? Yes / No

Is your knee swollen when you wake up in the morning? Yes / No

Mechanical symptoms:

Does your knee catch, lock or feel like it is getting stuck? Yes / No

Does your knee give out or buckle without warning? Yes / No

Do you trust your knee to keep you stable? Yes / No

Do you feel grinding within your knee? Yes / No

Neurovascular symptoms:

Do you feel numbness and/or tingling around your knee? Yes No

If so, where? _____

Do you feel unusually cold below your knee into your leg and foot? Yes / No

Do you notice swelling into your lower leg and foot? Yes / No

Prior knee problems:

Have you ever had any of the above symptoms with this knee before? Yes / No

If so, when? _____

Did these symptoms completely resolve? Yes / No

Have you ever had surgery on this knee in the past? Yes / No

Have you ever had problems with your other knee in the past? Yes / No

If so, please briefly explain: _____

Evaluation:

Please circle which tests you have had for these current knee symptoms so far:

X-Rays / CAT Scans / MRI / Bone Scans / Ultrasound

Treatment:

Have you taken any NSAID medications for this problem (ibuprofen/Advil, Naproxen, Aleve, Celebrex or similar medication not including Tylenol)? Yes / No

If yes please give approximate date started _____ stopped _____.

Have you tried Glucosamine sulfate with or without chondroitin sulfate? Yes / No

Have you taken narcotic pain pills for this problem (Vicoden, Percocet, etc.)? Yes / No

Have you had cortisone shots for this problem? Yes / No

If yes please estimate approximately how many and when? _____

Have you been to physical therapy for this problem? Yes / No

If yes please estimate start date and stop date: started _____ stopped _____.

Are you currently doing exercises on your own for this problem? Yes / No

Do you wear a brace or wrap on your knee or inserts in your shoes for this problem? Yes / No

If yes please briefly describe: _____

Comments:

Is there anything that I have not asked above that you think is important for me to know?

