



KNEE PAIN EVALUATION

Name: _____

1. If injured, date of injury:	Which knee?	R	L	
2. Is this injury due to an accident?	No	Yes	If yes, was it a Motor Vehicle Accident?	No Yes
If yes, did this injury occur at work?	No	Yes	What is your occupation?	
3. Are you currently out of work or on limited duty due to this injury?	No	Yes	How long?	
4. If not injured, date of onset of symptoms:	Duration of symptoms:			
5. Please write a brief description of how your injury or symptoms happened:				
6. Have you seen another doctor for this injury or these symptoms? No Yes If yes, who?				
7. Is this appointment for a second opinion? No Yes				
8. How far can you walk prior to pain?				
9. Do you avoid physical activity such as walking long distances, shopping, going up or down stairs? No Yes				
10. Do you have a regular exercise program? No Yes				
11. What is your pain at rest?	Least = 1 2 3 4 5 6 7 8 9 10 = Max			
12. What is your pain during or immediately after activity?	Least = 1 2 3 4 5 6 7 8 9 10 = Max			
13. How would you describe your symptoms?	<i>Annoying</i>	<i>Inconvenient</i>	<i>Restricting</i>	<i>Disabling</i>
14. Do you have a past history of knee problems? <i>Please describe briefly:</i>				
15. Have you had prior knee surgeries?	No	Yes	Which knee?	R L
When?	Where?	Surgeon?	Procedure:	
16. Are you taking Vitamin D? No Yes If yes, how much?				

Please indicate the symptoms you have by using "R" for right knee, "L" for left knee, or "B" for both knees:

Symptoms	How often?				Symptoms	How often?		
	daily	weekly	rarely			daily	weekly	rarely
Locking					Morning stiffness			
Giving way					Pain at night			
Catching					Pain with running			
Swelling					Pain with kneeling			
Clicking					Difficulty with stairs			
Popping					Difficulty with uneven terrain			
Grinding								

Please circle all previous treatments you have tried:

Ice Bracing Shoe Inserts Activity modification Cane or Walking stick Medications (Tylenol, Aleve, Celebrex)

Physical Therapy How Long? _____ Date _____

Chondroitin/glucosamine or other cartilage supplement Steroid Injection Date: _____

PRP Injection Date: _____ Hyaluronic Acid Injection (Euflexxa, Synvisc, Monovisc) Date: _____

Signature of Patient or Guardian

Date