KNEE

Name _____ Age _____ Date _____

Right Knee _____ Left Knee _____ Both Knees _____ Ht _____ Wt _____

Work Injury? _____ Auto Injury? _____ Date of Injury _____

How long has your knee bothered you? _____
How did the symptoms begin? _____
Are you getting better or worse? _____

History of Condition:

Location of Symptoms (circle all that apply):

KNEE Medial (inside) Lateral (outside) Patella (knee cap)
Down back of leg Up back of leg
Down front of leg Up front of leg Other? _____

QUALITY Sharp Dull Grinding Throbbing Tingling Giving Away
Electric Shock Constant Intermittent Other? _____

ASSOCIATED SYMPTOMS
Stiffness Where? _____
Numbness Where? _____
Swelling Where? _____
Catching Where? _____
Weakness Where? _____
Giving Away Where? _____

When do symptoms occur? (circle all that apply)

Walking Running Stairs Rising from Chair Night Morning
During Exercise After Exercise At Work Kneeling Squatting
Other? _____

What makes symptoms better? (circle all that apply)

Rest Therapy Heat Cold Brace Bandage
Walking Aid Exercise Other? _____

Do you have pain in any other joints? Where? _____
Are you able to walk up/down stairs? _____
Do you use support? _____ If yes, please describe? _____

Is there anything we should know about your knee?