Name:

DOB:

OrthoCincy

Date:

Knee Evaluation

Referring Physician: _____ Primary Care Physician: _____

Name a favorite hobby: _____ Which knee is affected? _____

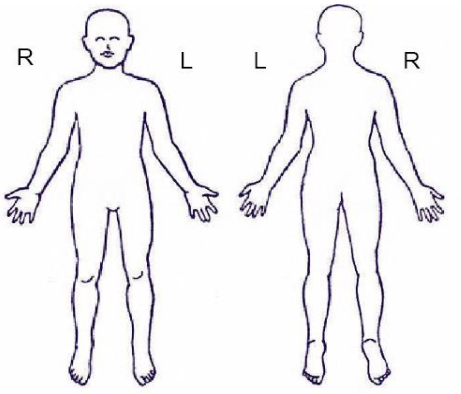
Describe how it happened: _____

Describe where you were: _____

☐ Personal Injury ☐ Fall ☐ Sports Injury ☐ Work related ☐ Chronic
☐ Auto Accident-were you wearing a seatbelt? ☐ yes ☐ no

The date the symptoms began: _____

On this diagram mark where your pain is:



For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: _____

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER _____

When is your pain worse? ☐ Mornings ☐ Evenings ☐ Always about the same

Is it worse after activity? ☐ yes ☐ no

What is your pain scale today: 0=no pain 10=worst pain	0 1 2 3 4 5 6 7 8 9 10 RIGHT	0 1 2 3 4 5 6 7 8 9 10 LEFT

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐ yes ☐ no
If so, please provide details: _____

What test have you had regarding this injury? ☐ **NONE** ☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ EMG/NCV
☐ Ultrasound ☐ Labs ☐ Other: _____

Have you had any treatment for this problem? ☐ **NONE** ☐ medication ☐ therapy ☐ splinting/brace ☐ injection
☐ surgery ☐ manipulation ☐ chiropractic treatment ☐ massage ☐ acupuncture ☐ pain specialist
☐ other: _____

- Was any of your treatment effective? Explain: _____

_____

- Where did you receive treatment? _____

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Put an X in the box that indicates your ability to do the following activities with the effected knee:

	Not Difficult at all	Minimally Difficult	Moderately Difficult	Extremely Difficult	Unable to do
Go up stairs					
Go down stairs					
Kneel on the front of your knee					
Squat					
Sit with your knee bent					
Rise from a chair					
Run straight ahead					
Jump and land on your involved leg					
Stop and start quickly					

Put an X in the box that indicates your ability to do the following activities:

	Very strenuous activities like jumping or pivoting as in basketball or soccer	**Strenuous** activities like heavy physical work, skiing or tennis	**Moderate** activities like moderate physical work, running or jogging	**Light** activities like walking, housework or yard work	**Unable** to perform any of the above activities due to knee
What is the highest level of activity that you can perform without significant knee **pain**?					
What is the highest level of activity that you can perform without your knee **giving way**?					
What is the highest level of activity that you can perform without significant knee **swelling**?					
What is the highest level of activity that you can perform **on a routine basis**?					

Patient Signature: _____

Provider Signature: _____ Date: _____