

KNEE RIGHT _____ LEFT _____ DATE: _____

Name: _____ Age _____ Height _____ Weight _____

Affected for: _____ days _____ months _____ years Injury Date _____ OR

Gradual Onset _____ Work Injury? Yes No Accident? No Yes Auto? Other?

How were you injured? _____ N/A

Pain: Rate your discomfortNone=0 1 2 3 4 5 6 7 8 9 10=Severe

Quality and Duration of the Pain: _____ Sharp _____ Dull _____ Burning _____ Throbbing

_____ Electric shocks _____ Constant _____ Intermittent (on and off)

In the past few days/weeks the pain has ___increased ___decreased ___stayed the same

Where do your symptoms occur? _____ Front _____ Back _____ Under kneecap

_____ Inside (medial) near other knee _____ Outside (lateral) away from other knee

When do your symptoms occur? _____ Walking _____ Running _____ Using stairs

_____ Rising from chair _____ During exercise _____ After exercise

_____ At work _____ After work _____ At night _____ In the morning Other: (describe)

If these symptoms occur (Yes) please describe when or where. If not, indicate "No"

Stiffness No Yes _____

Numbness No Yes _____

Swelling No Yes _____

Locking No Yes _____

Catching No Yes _____

Giving way No Yes _____

Weakness No Yes _____

Popping No Yes _____

Difficulty walking? Distance you can walk without pain or stopping to rest _____ block(s)

Unlimited=put "unl"

Losing range of motion? Yes No Legs Bowed? Yes No Knock-Knee? Yes No

Do you use supports to walk? None Cane 2 Canes Crutch 2 Crutches Walker

Can you walk stairs? No Yes _____ Normally or _____ One at a time

Can you get out of a chair? No Yes _____ Normally or _____ Push with hands

Have you had any other treatment for this problem? (i.e. injections, glucosamine, etc.)

No Yes (describe) _____

What improves your symptoms? N/A Medication (list) _____

_____ Rest _____ Physical therapy _____ Heat _____ Ice _____ Brace/bandage _____ Exercise

Reviewed by: _____ Neal L. Rockowitz, M.D.

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