

Date: _____

Patient Name: _____

DOB: _____

Patient Medical History for KNEE Symptoms

Referred by: _____ Date of Injury/Onset of Symptoms: _____

Reason for visit: Describe injury or onset in detail: Left Right

Pain: Sharp Dull Stabbing Burning Other: _____

Pain: Constant Intermittent

Pain Intensity (circle): 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

- 0 – No Pain
- 1 – Mild Pain, you are aware of the pain, but it does not bother you
- 2 – Moderate Pain – You can tolerate pain without medication
- 3 – Moderate Pain – Requires Medication to tolerate pain
- 4 – 5 – More Severe Pain – you begin to feel anti-social
- 6 – Severe Pain
- 7 – 9 - Intensely Severe Pain
- 10 – Most Severe Pain, Emergency Room Care

Location (describe): _____

Does the Pain go anywhere else (describe)? _____

What makes the pain worse? Standing Walking Running Stairs Squatting Pivoting Sitting Other?

What makes pain Better? Rest Activity Modification Ice/Heat Meds Brace

Other: _____

What other symptoms are present? Catching Popping Grinding Locking Giving Way

Buckling Swelling (Constant Fluctuates) Numbness/Tingling

Have you received an injection in your current problem area? NO YES If YES, when? _____

What treatments have you attempted and what effect (PT, Meds, Injections)? _____

Can you work or participate in sports with current symptoms? NO YES

Do you have light duty available at work? NO YES