

Name: _____

DOB: _____



* S H A R E D I D - 2 5 *

Date: _____

Knee Evaluation

Referring Physician: _____ Primary Care Physician: _____

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

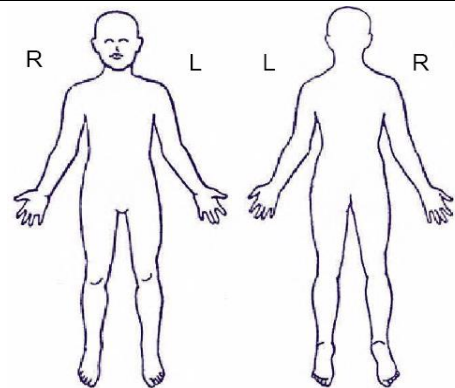
Describe how it happened: _____

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
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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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* S H A R E D I D - 2 5 *

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: _____