Knee History and Physical Exam

Patient Name: _____
Account #:_____ Date:_____

Please Complete This Form To Help Us Better Evaluate And Treat Your Knee.

Age___ Race____ Sex____ **Knee** - Right / Left *(circle one)* **Date Of Injury/Onset?_____**

Occupation_____ If retired, previous occupation: _____

Chief Complaint (Describe Problem_____
_____

HISTORY
Work Related?_____ Sports Related?_____

Describe Injury or Trauma Event in Detail_____
_____
_____

Check Problems You Have With Your Knee

__Soreness __Aching __Sharp Pain __Shifting __Looseness __Dislocating __Stiffness __Catching __Locking __Swelling __Weakness __Night pain

Athletics: Name of your sport?_____School:_____
How Problem Affects Your Ability To Play_____
_____

Rate Your Pain On A Scale From **1 (Least)** to **10 (Greatest).**

X = Pain At Rest **O** = Pain With Activity **Mark an X and O on the Line.**

_____
1 **5** **10**

Previous Treatment: ___Primary M.D. ___Orthopedic Surgeon ___Physical Therapist
Name of M.D. or Therapist _____
Change in Activities_____
Medications For Problem_____
Physical Therapy_____ How Long_____
Cortisone Injection?_____ How Many?_____When_____
Surgery: _____
_____