KNEE QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which knee(s) did you hurt? _____

2.) Is this a new presentation of knee pain, or a follow-up?_____

3.) Did another provider refer you? If yes, who?_____

4.) Where is your knee pain? (check all that apply)

__all over the knee (diffuse) __on the front of the knee __on the outside of the knee
__on the back of the knee __on the inside of the knee

5.) Describe **how** and **where** your symptoms occurred/how you injured your knee? Be specific (include **dates**)

_____

_____

6.) What best describes your knee pain? (check all that apply)

__aching __grinding __burning __electric __sharp other:_____
__acute __locking __chronic __improving __stabbing
__acute on chronic __popping __cramp-like __pins and needles __staying the same
__catching __pressure __diminishing __progressive __tender to touch
__clicking __throbbing __dull __radiating __worsening

7.) What is associated with your knee pain? (check all that apply)

__bruising __gait instability __radiation to ankle __stiffness other:_____
__chills __joint swelling __radiation to hip __the knee giving way
__fevers __limping __rashes __weakness

8.) Describe the timing of your pain? (check all that apply)

__began today __occurs episodically __occurs randomly other:_____
__constantly occurs __occurs in the morning __occurs with activity
__occurs at night __occurs intermittently __occurs with weight bearing

9.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___ /10 on a bad day ___ /10 on an average day ___ /10
initially ___ /10 on a good day ___ /10

10.) How long have you had your knee pain? ___years ___months ___weeks ___days

11.) What are you currently using to treat the knee pain? (check all that apply)

__aspiration __narcotics/pain meds __Tylenol
__brace __anti-inflammatory meds __no treatment
__exercise __physical therapy other:_____
__injections __rest, ice, and elevation
__muscle relaxants __topical cream

12.) Have you had any procedures or surgeries to treat the knee pain? If yes, what type?

_____

13.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__bone scan __MRI __ultrasound other:_____

__CT scan __plain radiographs (X-ray) __no imaging studies

14.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __difficulty with ADL's __working on a limited basis

__difficulty ascending stairs __difficulty with REC sports participation other:_____

__difficulty descending stairs __functional limitations

__difficulty getting up from a chair __inability to go to school

__difficulty kneeling __inability to perform ADL's

__difficulty sitting __inability to work

__difficulty squatting __requiring constant assistance

__difficulty standing __requiring occasional assistance

__difficulty walking __working light duty

15.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:_____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____	_____	_____
Patient's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____