NEW PATIENT KNEE QUESTIONAIRE

Patient Name_____Age_____Occupation_____

Which knee hurts? (circle one) RIGHT LEFT BOTH

Describe in detail the nature of the injury_____

Using the below symbols, mark the area on your knee where you feel the described sensations.
ACHING ΔΔΔΔ NUMBNESS ====== PINS & NEEDLES 00000 BURNING XXXXX Other ■ ■ ■

SEE BACK OF FORM FOR DIAGRAM

Rate your pain over the last week by putting a circle around the worst pain and a square around the least amount of pain.

LOWEST 1 2 3 4 5 6 7 8 9 10 **HIGHEST**

What makes the pain worse?_____

What makes the pain better?_____

Did you feel a pop when you injured it? (circle one) YES NO

Did your knee swell immediately? (circle one) YES NO

Does it feel stiff it you sit for a long period of time ? (circle one) YES NO Does it click (circle one) YES NO

Have you had any previous injuries or surgeries to your hip, knee, ankle on this side? (circle one) YES NO

If yes, describe_____

Does it hurt going up and/or down stairs? (circle one) YES NO

Have you previously had any physical therapy for this particular problem? (circle one) YES NO

If yes, when and where was the therapy performed?_____

Have you previously had injections for this problem? (circle one) YES NO

If yes, when and did the injection(s) help?_____

What medications do you take for this pain? (list all over-the-counter and prescription medications and analgesic rubs). _____

What is the most active thing you do with your legs, i.e., sports, chores, home repair or work related activity? _____

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