Knee Survey

Knee evaluated
Right  Left  Both

Is this work related?
☐ Yes  ☐ No

What is the problem with your knee?
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Is the problem getting
☐ worse  ☐ better  ☐ staying the same?

Is this related to an injury?
☐ Yes  ☐ No
If yes, describe how it happened.
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Which word best describes your pain?
☐ None  ☐ Mild  ☐ Moderate  ☐ Severe

Select one statement below regarding your knee pain.
☐ Normal function: I can do all activities of daily living, work and sports activities that I did before my knee problem.
☐ I have mild limitations in sports and work and activities of daily living.
☐ I have moderate limitations in activities of daily living. No sports possible.
☐ I have severe limitations. Cannot do usual work or lifting. No sports.
☐ Complete disability of he knee.

Where is the pain?
☐ Inner side  ☐ Front of knee cap  ☐ Outer side  ☐ Back of knee  ☐ All over

How often do you get pain?
☐ Never  ☐ Monthly  ☐ Weekly  ☐ Daily  ☐ Always

How bad is your pain today?
No pain> 0 1 2 3 4 5 6 7 8 9 10 <Worst pain imaginable

Describe the pain
☐ Constant  ☐ Comes and goes
☐ Dull  ☐ Sharp  ☐ Throbbing  ☐ Burning  ☐ Aching

Do your knee
☐ Pop  ☐ Click  ☐ Catch / locking  ☐ Give way (knee collapses or buckles)  ☐ Swell
☐ Grind

Check all that apply
☐ Knee stiffness in the morning
☐ Knee stiffness later in the day
☐ Stiffness after sitting, lying or resting
Have you had previous x-rays or MRI's of the shoulder?

When ________________________________________________________________________________
Where ________________________________________________________________________________

Have you had previous treatment for this condition?   ○ Yes  ○ No

When ________________________________________________________________________________
Who _________________________________________________________________________________

   ○ Physical therapy      ○ Medication      ○ Injections      ○ Other

Have you had previous surgery for this condition?

When ________________________________________________________________________________
Who _________________________________________________________________________________

What kind of surgery _____________________________________________________________________