



KNEE EVALUATION FORM

Name: _____ Date: _____

HISTORY OF KNEE PROBLEMS

LT KNEE ____ RT KNEE ____ WORK INJURY YES NO DATE OF INJURY: _____

PLEASE DESCRIBE ALL OF YOUR SYMPTOMS (CHECK ALL THAT APPLY)

PAIN (RATE YOUR DISCOMFORT) (CIRCLE) ONE 0 1 2 3 4 5 6 7 8 9 10

LOCATION OF PAIN (CIRCLE)

FRONT OF THE KNEE

BACK OF THE KNEE

UNDER KNEECAP

QUALITY AND DURATION OF THE PAIN (CIRCLE)

SHARP

DULL

BURNING

THROBBING

TINGLING

ELECTRIC SHOCKS CONSTANT INTERMITTANT (PAIN OFF AND ON)

____ STIFFNESS when? _____

____ SWELLING where? _____

____ CATCHING when? _____

____ DIFFICULTY WALKING Distance you can walk without having pain or stopping to rest ____ blocks

____ OTHER _____

Do you ever use supports to walk? (circle) **NONE CANE 2 CANES 2 CRUTCHES WALKER**

Can you walk stairs? (circle all that apply) **NO YES Normally One at a Time**

How long has your knee (s) been bothering you? _____

When do your symptoms occur? (check all that apply) ____ Walking ____ Running ____ Stairs

____ Raising from Chair ____ At Night ____ In the morning ____ During Exercise ____ After exercise

____ At Work ____ After Work ____ Other _____

What makes your symptoms better? (circle) ____ Rest ____ Therapy ____ Heat ____ Cold

____ Exercise ____ Brace/Bandage ____ Medication What? _____

Have you had any other treatment for this problem? (circle) **NO YES** If yes, describe: _____

