

INJURED / PAINFUL KNEE QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

Please check the circles below that apply to your knee:

- Right Knee Left Knee

HOW INJURED?

- Specific Injury -- Date of Injury _____
Mechanism of Injury -- Sport _____
Mechanism of Injury -- Other _____
- No Specific Injury -- Duration of Problem _____

SYMPTOMS

- Pain -- Circle intensity: Mild Moderate Severe
When does the pain occur? (e.g., activity, night, etc.) _____
- Swelling - Circle intensity: Immediate (less than 4 hours) Delayed Recurring
- "Pop"/"Snap" in knee
- Unstable Sensation/"Looseness"
- Locking/Unable to bend or straighten properly
- Kneecap unstable
- Difficulty with stairs
- Difficulty entering or leaving car
- Other _____

TREATMENT

Details

- Have you received treatment from: ER Primary Care Physician Specialist
- Name of physician or facility: _____
- None/Rest _____
- Brace/Cast _____
- Anti-inflammatory/Medications(for this injury - e.g. Aleve, Advil) _____
- X-Ray MRI Name of facility: _____
- Injection _____
- Rehabilitation/Therapy _____
- Surgery _____
- Return to Activity (&Date) _____

ACTIVITY

Primary Sport _____
What level? (e.g., college, recreational) _____
Other Sports _____
Runner? _____ miles x _____ day/week= _____ miles/week
How does knee injury affect these? _____

OCCUPATION

Job Description _____
How does your knee problem affect your job? _____