INJURED / PAINFUL KNEE QUESTIONAIRE

NAME _____ **AGE**_____ **DATE**_____

Please **check the circles** below that apply to your knee:

O **Right Knee** O **Left Knee**

HOW INJURED?

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

SYMPTOMS

O Pain -- Circle intensity: Mild Moderate Severe
When does the pain occur? (e.g., activity, night, etc.) _____
_____
O Swelling - Circle intensity: Immediate (less than 4 hours) Delayed Recurring

O "Pop"/"Snap" in knee
O Unstable Sensation/"Looseness"
O Locking/Unable to bend or straighten properly
O Kneecap unstable
O Difficulty with stairs
O Difficulty entering or leaving car
O Other _____
_____

TREATMENT **Details**

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