# KNEE – NEW INJURY

**Name**: ________________________________________________**DOB**: ___________________

**Who referred you?** ______________________________________________________________

**Side**: ☐ LEFT ☐ RIGHT

**Duration of symptoms**: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

☐ Days ☐ Months ☐ Years

**Was there an injury?** ☐ Yes ☐ No
**Associated pop**: ☐ Yes ☐ No
**Onset**: ☐ Sudden ☐ Gradual
**Work related?** ☐ Yes ☐ No
**Car accident?** ☐ Yes ☐ No
**Litigation involved?** ☐ Yes ☐ No

**Location of pain**: ☐ Front ☐ Back ☐ Inside ☐ Outside

☐ Hamstring ☐ Patella ☐ Quadriceps ☐ Patellar tendon

**Type of pain:** ☐ Burning ☐ Dull/Aching ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Throbbing ☐ Pinching ☐ Diffuse ☐ Localized ☐ Radiating

**Associated symptoms**:

**Numbness**: ☐ Yes ☐ No

**Tingling**: ☐ Yes ☐ No

**Tightness**: ☐ Yes ☐ No

**Instability**: ☐ Yes ☐ No

**Do you feel**: ☐ Clicking ☐ Catching ☐ Locking ☐ Weakness

**Does pain radiate**: ☐ Yes, radiates to ___________________________ ☐ No

**Limitations to daily activity**: ☐ Yes ☐ No

**Limitations to sports/exercise**: ☐ Yes ☐ No

**Progression**: ☐ worsening ☐ improving ☐ unchanged / same

**Pain at rest** ☐ Yes ☐ No

**If YES, on a 0 to 10 scale (0 being none and 10 being worst), how would you rate it?**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

**Current severity of pain:** ☐ none ☐ mild ☐ moderate ☐ severe

**On a 0 to 10 scale, how would you rate your pain right now**:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PLEASE TURN OVER

**Do you feel pain with activity?** ☐ Yes ☐ No

**If YES, on a 0 to 10 scale, how would you rate your pain with activity?**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

| **Treatments:** | **Helpful?** | **Not Tried:** |
|---|---|---|
| Physical Therapy: | Yes ☐ No ☐ | ☐ |
| Cortisone injection: | Yes ☐ No ☐ | ☐ |
| NSAIDs: | Yes ☐ No ☐ | ☐ |
| Chiropractor: | Yes ☐ No ☐ | ☐ |
| Ice: | Yes ☐ No ☐ | ☐ |
| Heat: | Yes ☐ No ☐ | ☐ |
| Massage: | Yes ☐ No ☐ | ☐ |
| Acupuncture: | Yes ☐ No ☐ | ☐ |
| Home exercise program: | Yes ☐ No ☐ | ☐ |
| Bracing: | Yes ☐ No ☐ | ☐ |
| Topical rubs: | Yes ☐ No ☐ | ☐ |

**Previous surgeries:** ______________________________________________

**Previous imaging/testing**: ☐ MRI ☐ Xrays ☐ CT ☐ EMG ☐ Bone Scan

**Smoking status**: ☐ Never ☐ Current ☐ Previous

**Current work status**: ☐ Regular Duty ☐ Light Duty ☐ Not working due to this injury

☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

**REVIEW OF SYSTEMS (Please Circle all that apply)**

| | | | |
|---|---|---|---|
| Abdominal pain/discomfort | Abnormal Menstrual periods | Back Pain | Chest Pain |
| Chills | Constipation | Depression | Diarrhea |
| Double Vision | Easy Bruising | Environment Allergies | Fatigue |
| Fever | Glasses | Headaches | Incontinence |
| Joint Pain (Arthralgia) | Leg swelling/pain | Neck Pain | Neck Stiffness |
| Nervousness/Anxiety | Numbness | Rash | Shortness of Breath |

**None of the Above**