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Glenview Outpatient Center

KNEE INJURY - INTAKE FORM

Name: _____ **Age:** _____ **DOB:** _____ **Today's Date:** _____

Primary care physician: _____ **Referred by** _____

Occupation: _____

Sports/Activities: _____

Which knee are you here for today? Right Left Both

When did your symptoms begin (specific date or in weeks/months/years**)?** _____

Was there a specific injury? Yes / No (If yes please describe): _____

_____

Prior surgery/injury to this knee? Yes / No (Describe) _____

NATURE OF SYMPTOMS

Is your pain getting: Better Worse Same

Please rate your *average* level of knee pain: (none) 1 2 3 4 5 6 7 8 9 10 (worst)

Where is most of your pain? Front Inside (Medial) Outside (Lateral) Back

Is your pain (or other symptoms): Constant Intermittent Associated with activity

Please list activities that are painful/difficult to perform: _____

_____

Is your pain: SHARP STABBING DULL ACHING

Do you have: a) Pain at night: Yes / No b) Pain with sitting: Yes / No

Please circle any of the following that you notice:

Loss of motion Popping Clicking Instability

Do you have visible knee swelling? Yes / No

Circle any activity which makes your pain worse

Squatting Running Going up stairs Going down stairs

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Does your knee give out? Yes / No

Do you notice a painful click, pop, or catch? Yes / No

Do you *suddenly* lose the ability to fully straighten your knee? Yes / No

PAST TREATMENT

Medications: _____ **Did it help?** Yes / No

Injections: Yes / No **How many?** _____ **Most recent** _____ **Did it help?** Yes / No

Physical therapy: Yes / No **How long?** _____ **Did it help?** Yes / No

Other treatment: _____