

Today's Date: _____

Physician Name: _____

Referring M.D.: _____

Name: _____ Age: _____

Occupation: _____

Which knee? Right _____ Left _____ Both _____

Describe problem and injury (if any) and date of onset: _____

How long have you experienced problems? _____

Have you had previous problems with this knee? Yes ____ No ____ When? _____

Describe: _____

Pain Scale (circle one):

1 2 3 4 5 6 7 8 9 10
Least moderate severe

Pain Quality:

Sharp Dull Throbbing
 Aching Burning

Does your knee: Lock Yes ____ No ____
 Catch Yes ____ No ____
 Swell Yes ____ No ____
 Give way Yes ____ No ____

Treatments you have tried for this problem:

Physical Therapy Yes ____ No ____
Injections Yes ____ No ____
Medications Yes ____ No ____

List: _____

Physician Signature: _____ Date: _____

KNEE