Print Form

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Knee Form

Please complete and bring with you to your appointment.

☐ Right ☐ Left

Symptoms:

Pain with activity ☐ Y ☐ N (describe): _____

Pain at rest ☐ Y ☐ N (describe): _____

Pain at night ☐ Y ☐ N (describe): _____

Locking ☐ Y ☐ N (describe): _____

Instability ☐ Y ☐ N (describe): _____

Limited motion ☐ Y ☐ N (describe): _____

Swelling ☐ Y ☐ N (describe): _____

Limited strength ☐ Y ☐ N (describe): _____

Decreased strength ☐ Y ☐ N (describe): _____

Treatment:

Oral medications? ☐ Y ☐ N (describe): _____

Oral medications helpful? ☐ Y ☐ N

Physical Therapy? ☐ Y ☐ N (describe): _____

Physical Therapy helpful? ☐ Y ☐ N

Braces ☐ Y ☐ N (describe): _____

Braces helpful? ☐ Y ☐ N

Injections ☐ Y ☐ N (describe): _____

Injections helpful? ☐ Y ☐ N

Similar problem on the other side? ☐ Y ☐ N (describe): _____

_____

Patient Name: _____ Date: _____

MM/DD/YYYY