

PATIENT HISTORY QUESTIONNAIRE

KNEE

NAME: _____ AGE: _____ TODAY'S DATE: _____

Which KNEE is painful? _____ How long has it been painful _____

Was there an injury to your KNEE(S)? _____ If yes, please describe: _____

Where is your pain located? (front, back, top, medial, lateral, etc.): _____

Describe your pain (dull, sharp, constant, aching, etc.): _____

What are some of your symptoms?

- | | | |
|--|--|--|
| <input type="checkbox"/> Swelling/Fluid | <input type="checkbox"/> Weakness | <input type="checkbox"/> Popping/Clicking |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Locking |
| <input type="checkbox"/> Instability | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Referred/Traveling Pain | <input type="checkbox"/> Buckling/Giving Out |

Pain Level: 1 2 3 4 5 6 7 8 9 10 (please circle)
Least Most

PREVIOUS TREATMENT:

1. Do you have any X-RAY's of your KNEE(S)? _____
If yes, when and where were they done & who was the ordering physician? _____
2. Do you have an MRI of your KNEE(S)? _____
If yes, when and at what facility did you have the MRI? _____
3. Are you taking medications specific to your KNEE pain? _____
If yes, which medication(s)? _____
4. Have you had previous treatment by another Doctor, any Physical Therapist, Acupuncturist, or Chiropractic treatment for your KNEE(S)? _____
If yes, by whom & when? _____
5. Have you had any surgery on your KNEE(S)? _____
If yes, by whom & when? _____
6. Is a legal case involved with this injury? _____ Is this a work related injury? _____

IF YOU ANSWERED YES TO EITHER ONE OF THE QUESTIONS IN #6, PLEASE FILL OUT THE WORK RELATED INJURY FORM.

THANK YOU