



Today's Date: \_\_\_\_\_

**KNEE QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **REFERRED BY?** \_\_\_\_\_

Which knee are we seeing you for today (please circle)?	Right	Left	Both
Occupation: _____	Are you currently working: _____		
Do you feel your injury is work related?	Yes		No
Is there an open work comp claim for this injury?	Yes		No
Is your claim in Litigation?	Yes		No

How was your knee injured (Include date, if any, and how long you have had a problem)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAIN**

Where in the knee does it hurt: \_\_\_\_\_

Frequency of pain:	Constant			Intermittent						
Pain Scale (circle one):	1	2	3	4	5	6	7	8	9	10
	Mild			Moderate				Severe		

Aggravating activities (please circle):

Stairs (up/down)	uneven ground	prolonged sitting	running
climbing	Squatting	kneeling	prolonged standing/walking

Other: \_\_\_\_\_

Walking Aid used: None Cane Crutches Walker Wheelchair Motorized Scooter

Giving out or dislocations Yes No

Locking, Catching, Clicking (circle all that apply) Yes No

Swelling Yes No

Loss of Motion Yes No

Prior Knee Problems Yes No

Prior Knee Surgery Yes No

**Treatment Received for current condition**

Medications \_\_\_\_\_

Injections \_\_\_\_\_

Physical Therapy (How many sessions) \_\_\_\_\_

Surgery \_\_\_\_\_

Other Physicians \_\_\_\_\_

Chiropractic \_\_\_\_\_