

PRECLINIC KNEE PATIENT SURVEY

Patient Name: _____ DOB: _____ Date: _____

Which knee will we be treating today? (please circle) RIGHT LEFT (if both, fill one form out for each knee)

Knee pain location: (please check all that apply) Inside Outside Backside Knee Cap

Irritation with activity is caused by: (please answer YES or NO)

_____ Walking _____ Standing _____ Stairs _____ Bending _____ Stooping _____ Kneeling _____ Carrying

_____ Lifting _____ Pushing _____ Exercise _____ *If yes, what type: _____

_____ Change of direction _____ Acceleration _____ Deceleration _____ Weather changes

Sensations from knee: (check all that apply)

_____ Weakness _____ Giving away _____ Instability _____ Stiffness _____ Something moving in or out of place

What activity may cause the above sensations? _____

Do you require the use of: (please answer YES or NO)

_____ Crutches _____ Cane _____ Brace _____ Sleeve _____ Ace Wrap Other: _____

Do you have stiffness with sitting driving or standing? YES NO Which one(s): _____

Do you have difficulty sleeping? YES NO **If yes, does a certain position or use of a pillow help?** YES NO

Do you have incomplete extension (straightening of the leg)? YES NO

Do you have limited flexion (bending of the leg)? YES NO

Are you unable to squat, kneel or rise from a squatting position? YES NO

Do these symptoms improve, stay the same or worsen after initial morning activity? _____

List medications that have improved these symptoms: _____

List any significant prior knee injuries, any history of trauma or surgeries: _____

Check any of the following treatments or studies that have been performed for this condition:

_____ CT Scan _____ MRI _____ Bone Scan _____ X-ray _____ Physical Therapy _____ Injection _____ Brace

Patient Signature: _____ **Date:** _____