Knee Pain Questionnaire

Name_____

Which knee is bothering you? Right Left Both

Did your knee pain start with a specific injury? Yes No
- If yes: Date of injury: _____
- Mechanism of injury _____
- Did you feel a pop or snap with the injury? Yes No
- Is the injury work related? Yes No

Did your pain start with a particular sport or activity? Yes No
- If yes, what started the pain? _____

If there was no injury, when did the pain start? _____

What part of your knee hurts? Front Inside Outside Back

What are your primary sports and/or activities? _____

How would you describe your pain? (constant, intermittent, mild, severe, etc.)

_____

Do any of the following increase your pain?

Prolonged walking:	Yes	Minimally	No
Prolonged standing:	Yes	Minimally	No
Going up or down stairs:	Yes	Minimally	No
Prolonged sitting:	Yes	Minimally	No
Getting up from a sitting position:	Yes	Minimally	No
Kneeling or squatting:	Yes	Minimally	No
Pivoting or twisting motions:	Yes	Minimally	No
Running:	Yes	Minimally	No
Sports:	Yes	Minimally	No

Is there anything else that increases your pain? _____

_____

Do any of the following decrease your pain?

Rest:	Yes	Minimally	No
Ice:	Yes	Minimally	No
Heat:	Yes	Minimally	No
Over the counter medicines (Tylenol/Advil)	Yes	Minimally	No
Prescription pain medicines:	Yes	Minimally	No

Is there anything else that decreases your pain? _____

_____

_____

Do you have any of the following symptoms?

Weakness in your leg:	Yes	Minimally	No
Giving way or buckling of your knee:	Yes	Minimally	No
Locking of your knee (unable to fully straighten):	Yes	Minimally	No
Clicking or catching in your knee:	Yes	Minimally	No
Grinding sensation in your knee:	Yes	Minimally	No
Swelling of your knee:	Yes	Minimally	No
Stiffness:	Yes	Minimally	No
Pain at night:	Yes	Minimally	No
Numbness or tingling in your leg:	Yes	Minimally	No

Are there any other symptoms that we need to know about regarding your knee?

_____

_____

Have you had any prior surgery to your knee(s)? Yes No

If yes, what type of surgery did you have and when did you have the surgery?

_____

_____

Have you had any prior treatment for your knee pain such as:

Cortisone injections:	Yes	No
Synvisc, Euflexxa or "Gel" injections:	Yes	No
Physical therapy:	Yes	No

Do you use any ambulatory aids (cane, crutches, walker) Yes No

Have you had any x-rays taken of your knee(s): Yes No

If yes: Date of x-rays: _____

X-ray facility: _____

Have you had an MRI of your knee(s): Yes No

If yes: Date of MRI: _____

MRI facility: _____

Is there anything else we need to know about your knee pain?

_____

_____

_____

_____

Thank you for filling out this form