

**THE CENTER FOR ADVANCED SPORTS MEDICINE
KNEE AND SHOUDLER**

KNEE INTAKE FORM

Name: _____ Date: _____

Occupation: _____ Age: _____

Referred by: _____

Primary Care Physician: _____

CHIEF COMPLAINT:

- Is your problem in the: Right knee Left knee Both
- How long have you had this problem? _____
- Is your problem getting: Worse Better Staying the same
- Was this the result of an injury? YES NO

If yes, please describe how it happened: _____

- Is this a worker's compensation injury? YES NO

If yes, please answer the following questions. If no, please advance to next heading

1. Job title: _____

2. Date of injury: _____

3. Are you: Off work Modified/light duty Full duty

4. If you are not working, what date did you last work? _____

SYMPTOMS:

- If you are experiencing pain, where is it located?
Front of knee Back of knee Inside surface of knee
Outside surface of knee Behind knee cap
- Please rate the intensity of your pain/discomfort. (0 = no pain; 10 = severe pain)
0 1 2 3 4 5 6 7 8 9 10
- How often do you experience knee pain?
Never Monthly Weekly Daily Always

- What amount of knee pain have you experienced the last week during the following activities?
 - Twisting/pivoting on your knee

YES	NO	YES	NO	YES
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 - Straightening your knee fully

YES	NO	NO	YES	NO
-----	----	----	-----	----
 - Bending knee fully

YES	Unk	NO	Unk	YES
-----	-----	----	-----	-----
 - Walking on flat surface

NO	Unk	YES	NO	Unk
----	-----	-----	----	-----
 - Going up or down stairs

YES	NO	YES	NO	N/A
-----	----	-----	----	-----
 - At night while in bed

N/A	YES	NO	YES	N/A
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 - Sitting or lying

NO				
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 - Standing upright

	Yes	No	If yes, please describe
Stiffness			_____
Numbness			_____
Swelling			_____
Weakness			_____
Instability			_____
Other			_____

PRIOR TREATMENT:

- Have you tried any of the modalities below? Symptoms relieved?

	Yes	No	Description	(Y/N)
○ Medication			Names: _____	_____
○ Physical therapy			Length of time: _____	_____
○ Injections			How many: _____	_____
○ Other			Describe: _____	_____

MEDICAL HISTORY:

- Do you have a current or past history of the following?

Yes No Please describe all "yes" responses.

- Heart problem _____
- Lung problem _____
- High blood pressure _____
- Diabetes _____
- Cancer _____
- Stomach problems _____
- Kidney problems _____
- Liver problems _____
- Seizures _____
- Thyroid problems _____
- Other _____

- Please list all medications you are currently taking with dosage and frequency:

- Do you have any allergies to medication? YES NO If yes, please list:

- Please list past surgeries and hospitalizations:

- Do you drink alcohol? YES NO If yes, how much per week? _____

- Do you smoke? YES NO If yes, how much per day? _____
How long have you smoked? _____

- Do you use a special diet? YES NO If yes, describe: _____

- Do you exercise? YES NO If yes, describe: _____

- Sports/Hobbies: _____

- How tall are you? _____ How much do you weigh? _____