THE CENTER FOR ADVANCED SPORTS MEDICINE
KNEE AND SHOULDER

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
  - 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
  - Sitting or lying

    ☐ NO ☐ ☐ ☐ ☐
  - 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 of past history of the following?

	Yes	No	Please describe all "yes" responses.
o Heart problem	☐	☐	_____
o Lung problem	☐	☐	_____
o High blood pressure	☐	☐	_____
o Diabetes	☐	☐	_____
o Cancer	☐	☐	_____
o Stomach problems	☐	☐	_____
o Kidney problems	☐	☐	_____
o Liver problems	☐	☐	_____
o Seizures	☐	☐	_____
o Thyroid problems	☐	☐	_____
o 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?_____