HealthZone MD
FAMILY AND SPORTS MEDICINE WELLNESS CENTER

Knee Form

Name: _____

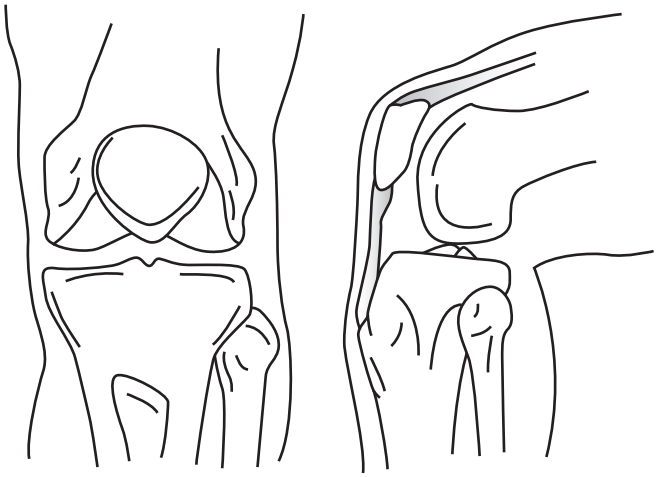
Date: M M / D D / Y Y Y Y

IDENTIFYING THE PAIN

Describe the injury/problem and past knee history

Please indicate the problem area with the following:

XXXX Sharp Pain //// Dull Ache - - - - Numbness or Tingling



Date of original injury
M M / D D / Y Y Y Y

Which Knee ❑ Right ❑ Left

Which is Worse ❑ Right ❑ Left

Does your knee:

Lock	❑ Yes	❑ No	Swell Immediately after injury	❑ Yes	❑ No
Grind	❑ Yes	❑ No	Swell Later	❑ Yes	❑ No
Pop	❑ Yes	❑ No	Swell Occasionally	❑ Yes	❑ No
Give Way	❑ Yes	❑ No			

PAIN

	Right	Left
None, Mild, Non-Limiting	❑ 15	❑ 15
Transient Limitation	❑ 8	❑ 8
Vigorous Activity Mild Limitation	❑ 12	❑ 12
Intermittent/Episodic Transient Limitation	❑ 4	❑ 4
Constant/Frequent Severe Limitation	❑ 0	❑ 0
Other: _____	❑ 10	❑ 10

LIMITATION

	Right	Left
None	❑ 10	❑ 10
Mild - No Handicap	❑ 7	❑ 7
Severe - Definite Handicap	❑ 0	❑ 0
Limited/Other: _____	❑ 10	❑ 10

SWELLING

	Right	Left
None	❑ 5	❑ 5
Activity Related Only	❑ 4	❑ 4
Occasional	❑ 3	❑ 3
Frequent	❑ 1	❑ 1
Chronic	❑ 0	❑ 0
Positive/Other: _____	❑ 3	❑ 3

INSTABILITY

	Right	Left
None	❑ 20	❑ 20
Slight - No Reaction	❑ 18	❑ 18
Mild - Some Disability	❑ 12	❑ 12
Moderate - Definite Limitation	❑ 6	❑ 6
Severe - Market Limitation	❑ 0	❑ 0

WALKING

	Right	Left
Unlimited	❑ 10	❑ 10
Smooth Surface Okay	❑ 7	❑ 7
Limited by Pain &/or Instability on Any Surface	❑ 4	❑ 4
Requires Support (Cane, Brace, Etc.)	❑ 0	❑ 0

RUNNING

	Right	Left
Unlimited	❑ 10	❑ 10
Speed Caution	❑ 8	❑ 8
Trouble Changing Direction	❑ 4	❑ 4
Unable	❑ 0	❑ 0

STAIRS/INCLINES

	Right	Left
No Difficulty	❑ 10	❑ 10
Mild Difficulty	❑ 8	❑ 8
Moderate Difficulty (one step at a time)	❑ 4	❑ 4
Unable	❑ 0	❑ 0

JUMPING

	Right	Left
No Difficulty	❑ 5	❑ 5
Difficulty	❑ 3	❑ 3
Unable	❑ 0	❑ 0

WORK/ACTIVITY

	Right	Left
Unlimited	❑ 15	❑ 15
Mild Limitation	❑ 12	❑ 12
Moderate Limitation	❑ 8	❑ 8
SevereLimitation	❑ 5	❑ 5
Unable	❑ 0	❑ 0

TOTALS	Right: 0	Left: 0

Reset

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