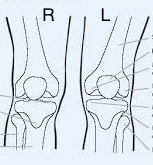
**KNEE EVALUATION**

**On this diagram mark where your pain is:**

****

**\*\*\*Weight: \_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\*\*\***

For each, circle what **BEST** applies:

* The pain is: OCCASIONAL INTERMITTENT CONSTANT
* The pain is: DULL SHARP ACHY THROBBING BURNING STABBING

Circle **ALL** symptoms that apply:

CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS

INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN

Have you ever experienced any injury to or symptoms involving this body part in the past? **Yes / No**

Provide Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests have you had regarding this injury? None: \_\_\_\_\_\_ X-Rays: \_\_\_\_\_\_\_ MRI: \_\_\_\_\_\_ CT Scan: \_\_\_\_\_ EMG/NCV: \_\_\_\_\_\_

Have you had any treatment for this injury? None: \_\_\_\_\_\_\_\_ Medications: \_\_\_\_\_\_ Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery: \_\_\_\_\_\_ Injections: \_\_\_\_\_\_\_\_ Pain Management: \_\_\_\_\_\_

Was any of the treatment effective? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Put an X in the box that indicates your ability to do the following activities with the effected knee:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not Difficult at all: | Minimally Difficult: | Moderately Difficult: | Extremely Difficult: | Unable to Do: |
| Go up stairs |  |  |  |  |  |
| Go down stairs |  |  |  |  |  |
| Kneel |  |  |  |  |  |
| Squat |  |  |  |  |  |
| Sit with your knee bent |  |  |  |  |  |
| Rise from a chair |  |  |  |  |  |
| Run straight ahead |  |  |  |  |  |
| Jump and land on knee |  |  |  |  |  |
| Stop and start quickly |  |  |  |  |  |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Lawrence Lenderman or my insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE