

**Knee Information Sheet**  
 (please fill out entire sheet)

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 (Last) (First) (MI)

**Progression of Symptoms:**

Date of injury? \_\_\_\_\_ Describe how this injury occurred: \_\_\_\_\_

How often do you have pain? \_\_\_\_\_

What helps it go away? \_\_\_\_\_

Have you missed work because of this pain? Yes No, If Yes, how much time? \_\_\_\_\_ Last date worked? \_\_\_\_\_

How long has your current pain been present? \_\_\_\_\_ Describe your pain: \_\_\_\_\_

Does your pain radiate into other areas? Yes No, If Yes, please describe: \_\_\_\_\_

Does your knee-cap ever come out of joint? Yes No, If Yes, Describe when and how: \_\_\_\_\_

Do you have pain climbing stairs? Yes No, If Yes, Describe: \_\_\_\_\_

Do you have pain running? Yes No, If Yes, Describe: \_\_\_\_\_

Do you have swelling? Yes No ...Did you have swelling within 2 hours of injury? Yes No

Do you have locking (cannot straighten the knee)? Yes No, If Yes, Describe: \_\_\_\_\_

Do you have weakness? Yes No, If Yes, Describe: \_\_\_\_\_

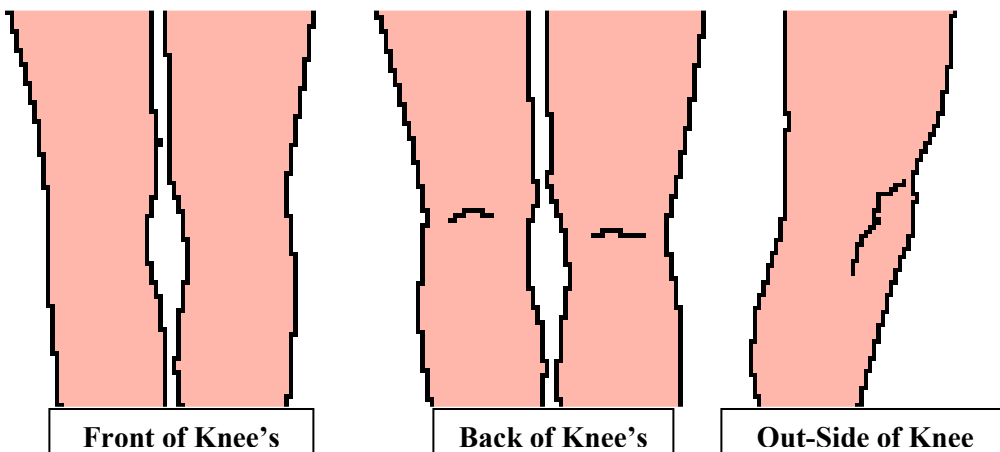
Do you have catching or popping sensations? Yes No, If Yes, Describe: \_\_\_\_\_

Have your symptoms changed since your initial injury? Yes No, If Yes, Describe: \_\_\_\_\_

What athletics are you engaged in? \_\_\_\_\_

Mark the area on your body where you feel the described sensations. Use the appropriate symbols. Include all affected areas.

Complete the picture, please draw a circle "○" to indicate your knee caps on the Front of Knee's diagram.



Sharp ///// Popping Or Clicking xxxxxxxx Locking oooooooooo Dull & Aching -----
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**Treatments:**

For this condition what treatments have you received?

Type of Surgery	Doctor	Where	Date	How did Your Symptoms Change after Surgery?

Have you seen an Athletic Trainer for this problem? Yes No, If Yes, Who? \_\_\_\_\_ Did it help, describe? \_\_\_\_\_

Have you seen a Massage Therapist for this problem? Yes No, If Yes, Who? \_\_\_\_\_ Did it help, describe? \_\_\_\_\_

Have you seen an Acupuncturist for this problem? Yes No, If Yes, Who? \_\_\_\_\_ Did it help, describe? \_\_\_\_\_

Have you seen a Physical Therapist for this problem? Yes No, If Yes, Who? \_\_\_\_\_ Did the Physical Therapist treat you with? Ultrasound Massage Traction Tens Unit Electric Stim .....Did it help, describe? \_\_\_\_\_

Do you have a Home Exercise Program? Yes No      Are you on a Work Harding Program? Yes No  
 Are taking any Pain Medications? (list all prescription and over-the-counter) \_\_\_\_\_

**Medical Records:**

List all the doctors you have seen for this problem:

Name of Doctor	Address of Doctor	Phone # of Doctor	Date of Last Treatment

Have you had the following tests? If so, please list:

Name of Test	Name of Doctor that ordered Test	Where was the Test Performed	Date of Test
MRI			
Bone Scan			
Electrical Studies _____			
X-rays			

**\*\* The Patient is responsible for bringing medical records, X-rays, MRI's ...etc to the appointment or you may have them sent to us, but you will be responsible for returning them.**