

KNEE QUESTIONNAIRE

NAME: _____ DATE: _____

1. HOW LONG HAS YOUR KNEE HURT? _____
2. BRIEFLY DESCRIBE THE PAIN _____

3. IS THE PAIN CONSTANT OR INTERMITTENT? (CIRCLE)
4. WAS THE ONSET OF PAIN THE RESULT OF AN INJURY? Y N
IF NO GO TO QUESTION 5
 - 4a. IF YES, BRIEFLY DESCRIBE _____

 - 4b. DID THIS INJURY HAPPEN AT WORK? Y N
 - 4c. WAS YOUR KNEE STRUCK BY ANOTHER OBJECT? Y N
IF YES, EXPLAIN _____
 - 4d. DID YOU HEAR A POPPING SOUND? Y N
 - 4e. WAS THERE ANY SWELLING? Y N
 - 4f. WAS THERE DISCOLORATION? Y N
5. DID THE PAIN COME ON GRADUALLY? Y N
6. DOES YOUR KNEE PAIN WAKE YOU UP AT NIGHT? Y N
7. DO YOU EVER FEEL A "GIVING WAY" SENSATION IN YOUR KNEE? Y N
8. DOES YOUR KNEE EVER "LOCK UP" & BECOME STUCK IN ONE POSITION? Y N
9. DO EVER NOTICE ANY SWELLING? Y N
10. DO YOU EVER FEEL ANY NUMBNESS OR TINGLING IN ANY PART OF YOUR
LEGS OR FEET? Y N
11. DO YOU EVER FEEL A WARM SENSATION IN YOUR KNEE? Y N
12. IS THE PAIN WORSE GOING UP AND DOWN STAIRS? Y N

13. WHAT MAKES THE PAIN BETTER? _____

14. WHAT MAKES THE PAIN WORSE? _____

15. HAVE YOU EVER HAD KNEE PAIN IN THE PAST? Y N
IF YES, BRIEFLY DESCRIBE IF DIFFERENT FROM CURRENT PAIN _____

16. HAS YOUR PAIN KEPT YOU FROM WORKING? Y N HOW LONG _____

17. DOES YOUR JOB REQUIRE YOU TO PERFORM A LOT OF (CIRCLE) STANDING
WALKING, BENDING, TWISTING, LIFTING.

18. HAS YOUR KNEE PAIN PREVENTED YOU FROM PERFORMING ANY OF YOUR
NORMAL DAILY ACTIVITIES? Y N IF YES, EXPLAIN _____

19. WHAT DOCTORS HAVE YOU SEEN REGARDING YOUR KNEE?

NAME	DATE	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. WHAT DIAGNOSTIC TESTING HAVE YOU HAD DONE?

TYPE OF STUDY	DATE
_____	_____
_____	_____
_____	_____

NAME: _____

DATE: _____