

Patient INTAKE Survey Knee

Name:	Date:
Date of Birth:	Sex:

Today, how much does or would the problem for which you are seeking attention limit:	Extreme Difficulty/Unable to Perform	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework, or school activities?					
2. Getting into or out of the bath?					
3. Walking between rooms?					
4. Squatting?					
5. Lifting an object, like a bag of groceries from the floor?					
6. Performing light activities around your home?					
7. Walking two blocks?					
8. Getting up or down one flight of stairs?					
9. Standing for one hour?					
10. Running on uneven ground?					

11.) Please indicate the amount of pain you have had in the last 24 hours (circle one):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

12.) How many surgeries have you had for this condition? _____

13.) How many days ago did this condition begin? _____

14.) Are you taking prescription medication for this condition? _____

15.) Have you received treatment for this condition before? _____

16.) I am apprehensive about doing physical activities which might make my pain worse (circle one).

Completely disagree 1 2 3 4 5 6 7 Completely agree

17.) How often have you completed at least 20 minutes of exercise such as jogging, cycling or brisk walking prior to the onset of your condition?
 3 or more times per week Once or twice a week Seldom or Never

18.) What is your present employment status? (Mark one)

- Employed and presently working full duty at same job
- Employed and presently working full duty at different job
- Employed and presently working restricted duty at same job
- Employed and presently working restricted duty at different job
- Employed but presently not working due to my condition
- Previously employed and receiving disability benefits for my condition
- Unemployed
- Retired
- Student
- Other

19.) Other health problems may affect your treatment. Please check any of the following that apply:

<input type="checkbox"/> Arthritis (rheumatoid/osteoarthritis)	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease or emphysema	<input type="checkbox"/> Kidney, Bladder, Prostate or Urination Problems
<input type="checkbox"/> Angina	<input type="checkbox"/> Allergies (medication, latex)
<input type="checkbox"/> Congestive Heart Failure (heart disease)	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Heart Attack (Myocardial Infarction)	<input type="checkbox"/> Anxiety or Panic Disorder
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression
<input type="checkbox"/> Neurological Disease	<input type="checkbox"/> Other disorders
(Multiple Sclerosis, Parkinson's)	<input type="checkbox"/> Hepatitis/AIDS
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Sleep dysfunction
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fever/Chills/Sweats
<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Numbness or Tingling
(ulcer, hernia, reflux, bowel, liver, gallbladder)	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Dizziness/Lightheadedness
<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Difficulty with balance while walking
	<input type="checkbox"/> Falls

Please list all medications you are currently taking:	Please list all surgeries you have had: