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Direction of Feed

# Knee

Please answer every question

***STAFF:*** *Handwritten items must be entered* ***MANUALLY***.

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH — Month / Day / Year

AGE

## AFFECTED SIDE

| | left | right | both |
|---|---|---|---|
| knee | ○ | ○ | ○ |

## ONSET OF SYMPTOMS

**Which best describes how your symptoms began?**
○ due to an injury ○ gradual onset ○ sudden onset

**How long ago did the symptoms begin?**
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ >10
○ days ago ○ weeks ago ○ months ago ○ years ago

**If you do not remember when your symptoms began, please describe how long you have been experiencing the symptoms:**

**Over the last:** ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16+
○ weeks ○ months ○ years

## TIMING

○ constant
○ intermittent
○ occasional
○ rare
○ daytime
○ nighttime
○ pain causes me to wake up from sleep
**other:** ____________

## HOW DID YOUR PROBLEM START?

○ at home
○ at work
○ during athletic activities
○ non-vehicle accident
○ motor vehicle accident
○ no known cause
**other:** ____________

**If you have had multiple injuries, please describe:** ____________

## MECHANISM

○ pulling
○ twisting
○ lifting
○ bending
○ direct blow
○ fall
○ sleep position
○ repetitive motion
○ reaching
**other:** ____________

## PAIN

**Are you currently experiencing pain?** ○ yes ○ no

**How much pain are you experiencing...** **0 = no pain** **10 = intolerable**

| | ☺ | | | | | | | | | | | | ☹ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NOW:** | No Pain | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 | Intolerable |
| **AT ITS WORST:** | No Pain | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 | Intolerable |

## QUALITY

○ sharp
○ dull
○ aching
○ burning
○ stabbing
○ throbbing
○ stinging
**other:** ____________

## ASSOCIATED SIGNS AND SYMPTOMS

○ stiffness
○ weakness
○ locking
○ catching
○ numbness
○ tingling
○ giving way
**other:** ____________

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SAMPLE

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Direction of Feed

# Knee

Please answer every question

*STAFF: Handwritten items must be entered **MANUALLY**.*

## PROGRESSION

- ◯ worsening
- ◯ improving
- ◯ resolved
- ◯ unchanged
- **other:** ______________________

## WHAT MAKES YOUR PAIN WORSE?

- ◯ **nothing makes the pain worse**
- ◯ lying down
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ climbing stairs
- ◯ getting out of a chair
- ◯ bending forward
- ◯ bending backward
- ◯ coughing
- ◯ sneezing
- **other:** ______________________

## WHAT MAKES YOUR PAIN BETTER?

- ◯ **nothing makes the pain better**
- ◯ ice
- ◯ heat
- ◯ rest
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ lying down
- ◯ using a brace
- ◯ using a splint
- ◯ using crutches
- ◯ elevation
- ◯ stretching
- ◯ prescription medication
- ◯ over-the-counter medication
- ◯ changing activities
- ◯ massage
- ◯ physical therapy
- ◯ injections
- ◯ chiropractor
- ◯ previous surgery
- ◯ medications
- **other:** ______________________

## TREATMENT HISTORY

**Have you gone to any other locations for today's problem?**

- ◯ **none**
- ◯ Urgent Care
- ◯ Emergency Room
- ◯ Chiropractor
- ◯ Inpatient Evaluation
- ◯ Primary Care Provider
- ◯ Other Ortho Physician
- ◯ Other Physician at this Location
- **other:** ______________________

**Have you had any of the following for today's problem?**

- ◯ X-Ray
- ◯ CT Scan
- ◯ MRI
- **other:** ______________________

## WORK HISTORY

**Are you currently working?**

- ◯ no (If no, when did you last work?): ______________________
- ◯ yes
- ◯ disabled
- ◯ retired

**Are you currently on any work restrictions?**

- ◯ no
- ◯ yes (please explain): ______________________

**Occupation:** ______________________ **Employer:** ______________________

## CURRENT SYMPTOMS

**Please mark all symptoms you are CURRENTLY experiencing.**
**Mark all that apply. If no symptoms in a category, please mark "NONE."**

| Category | Symptoms | | None |
|---|---|---|---|
| **GENERAL** | trouble sleeping ◯<br>recent weight loss ◯ | fatigue ◯<br>loss of appetite ◯ | **NONE** ◯ |
| **CARDIOVASCULAR** | chest pain ◯ | palpitations ◯ | **NONE** ◯ |
| **SKIN** | frequent rashes ◯<br>skin ulcers ◯ | lumps ◯<br>non-healing wound ◯ | **NONE** ◯ |
| **EAR / NOSE / THROAT** | hearing loss ◯ | hoarseness ◯<br>trouble swallowing ◯ | **NONE** ◯ |
| **ENDOCRINE** | cold intolerance ◯ | heat intolerance ◯ | **NONE** ◯ |
| **EYES** | vision loss ◯ | blurred vision ◯<br>double vision ◯ | **NONE** ◯ |
| **GASTROINTESTINAL** | heartburn ◯<br>nausea ◯ | vomiting ◯<br>blood in stool ◯ | **NONE** ◯ |
| **GENITOURINARY** | blood in urine ◯ | painful urination ◯ | **NONE** ◯ |
| **HEMATOLOGIC / LYMPHATIC** | easy bruising ◯ | easy bleeding ◯ | **NONE** ◯ |
| **NEUROLOGICAL** | headaches ◯ | dizziness ◯<br>numbness ◯ | **NONE** ◯ |
| **PSYCHIATRIC** | feeling anxious ◯ | feeling depressed ◯ | **NONE** ◯ |
| **RESPIRATORY** | chronic cough ◯ | shortness of breath ◯ | **NONE** ◯ |

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