PRO SPORT ORTHOPEDICS
EMPOWERING HUMAN PERFORMANCE

NEW KNEE PATIENT INTAKE FORM

Full Name: _____ **Date:** _____

What is your chief complaint/reason for the visit?_____

Occupation/Employer:_____

Which knee would you like to discuss today?(check one) ☐ Right ☐ Left ☐ Bilateral

Are your symptoms: (check one) ☐ New ☐ Recurrent ☐ Chronic

Did your symptoms begin: (select one option) ☐ Insidiously ☐ Suddenly

Where were you when your symptoms first began? (select one option)

☐ Home ☐ Skilled nursing facility ☐ Work ☐ School ☐ The gym ☐ While ☐ traveling
☐ Other:_____

When did your symptoms first occur? (provide a date or the most accurate time frame):_____

Describe what caused your symptoms?_____

_____

_____

How have your symptoms evolved since the onset? (select all that apply)

☐ Intermittent
☐ Constant
☐ Mildly progressive
☐ Moderately progressive
☐ Severely progressive
☐ Improving gradually
☐ Improving quickly
☐ Improving and have completely resolved

What symptoms are you experiencing? (select all that apply)

☐ Pain with normal daily activities
☐ Night pain
☐ Shoulder instability
☐ Weakness
☐ Hypersensitivity
☐ Numbness (complete absence of sensation)
☐ Pain with overhead lifting
☐ Mechanical sensations with motion
☐ Stiffness
☐ Fatigue
☐ Deficient sensation

Have you had any prior injuries, dislocations, or surgeries involving this knee?

☐ No ☐ Yes, please describe:_____

If you have had prior dislocations, please answer the following:

☐ Did the dislocation involve the patella (knee cap) or the main knee joint?:_____
☐ Total number of dislocations:_____
☐ Date of most recent dislocation:_____
☐ How was the patella/knee first dislocated?_____
☐ How was the patella/knee dislocated most recently?_____

☐ How has the knee been relocated? (select all that apply)

- ☐ Spontaneously (on its own)
- ☐ Manually reduced at the scene
- ☐ Reduced in an urgent care/ER setting
- ☐ Reduced in an ER with conscious sedation
- ☐ Can you "pop" your patella in an out yourself?_____

If you feel knee pain, please describe it (select all that apply):

☐ Shock-like ☐ Aching ☐ Shooting ☐ Dull
☐ Sharp ☐ Throbbing ☐ Deep

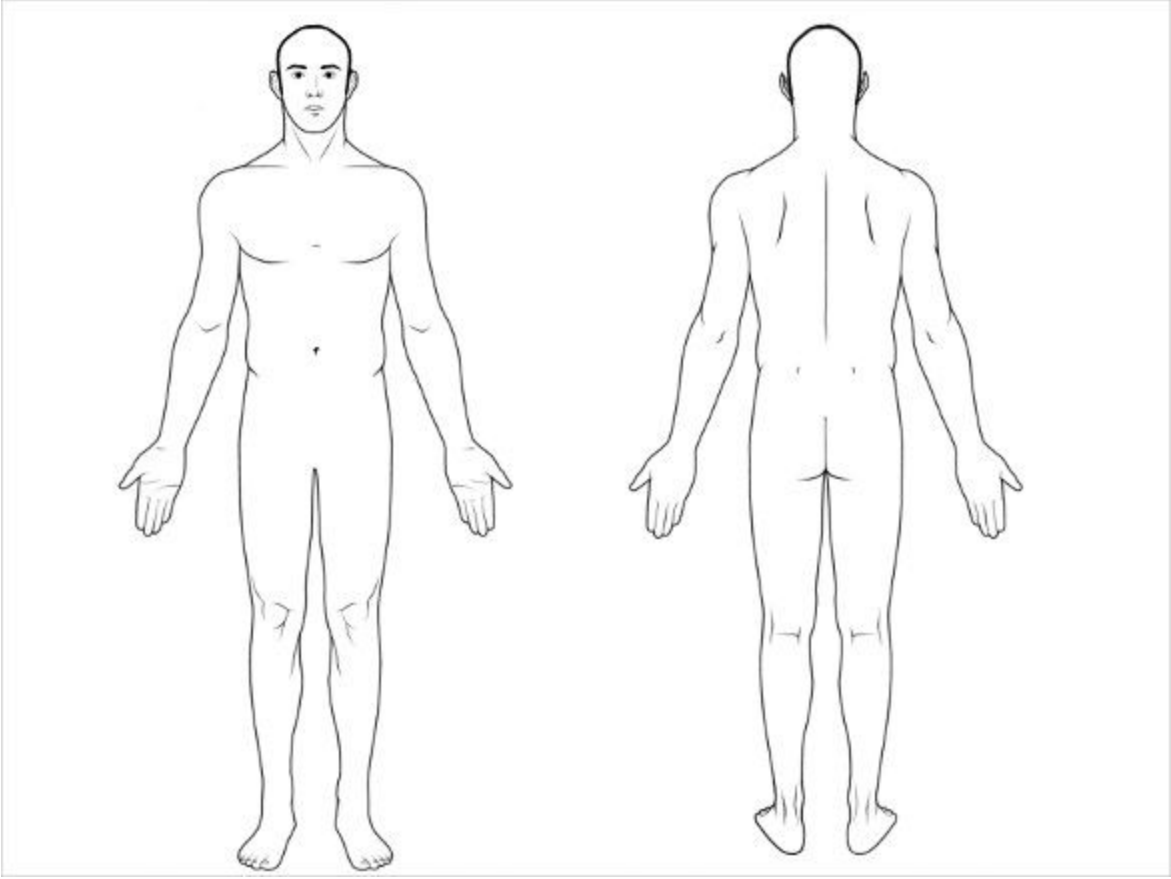
How severe is the pain on a scale from 1 (minimal) to 10 (most severe)?_____

Nature of pain (select all that apply): ☐ Localized ☐ Diffuse

Please use the diagram below to indicate where you feel symptoms.

Use the following key to indicate the different type of symptoms

Stabbing pain: xxxxxxx Burning pain: ///////////////
Deep Ache: 0000000 Pins and Needles: zzzzzzz



Does your knee pain radiate? (select all that apply)

☐ No ☐ Pain radiating down the leg, but remaining above the foot

☐ Pain radiating down the leg, extending to the top of the foot
☐ Pain radiating down the leg, extending to the bottom of the foot

What aggravates your symptoms? (select all that apply)

☐ Standing
☐ Sitting
☐ Squatting/kneeling
☐ Walking
☐ Running
☐ Pivoting or changing direction
☐ Jumping
☐ Ascending stairs
☐ Descending stairs
☐ Carrying loads >20 pounds
☐ Cycling
☐ Exercising
☐ Performing typical job-related tasks
☐ Working around the home
☐ Sleeping
☐ Nothing

What improves your symptoms? (select all that apply)

☐ Rest
☐ Cold therapy
☐ Heat therapy
☐ Physical therapy
☐ Chiropractic treatments
☐ Massage
☐ Stretching
☐ NSAIDs
☐ Narcotics
☐ Non-narcotic pain medications
☐ Corticosteroid injections
☐ Exercise
☐ Nothing
☐ Other:_____

Do you have any numbness or tingling in the same extremity? ☐ Yes ☐ No

What is your goal of treatment? (select all that apply)

☐ Decrease pain
☐ Increase strength
☐ Increase range of motion
☐ Increase function
☐ Prevent further decline in function
☐ Maintain employment
☐ Avoid surgery
☐ Return to pre-injury status

What treatments have you attempted? (select all that apply)

☐ None
☐ Rest
☐ Cold therapy
☐ Heat therapy
☐ Over-the-counter pain medications
☐ Anti-inflammatory medications/NSAIDs
☐ Narcotics
☐ Non-narcotic pain medications
☐ Self-directed home exercise program
☐ Other:_____

Have you attempted any provider-directed rehabilitation or therapy program? (select one option)

☐ No ☐ Yes, but for less than 6 weeks within the past 3 months
☐ Yes, for greater than 6 weeks within the past 3 months

If you have had provider-directed rehab:

What type of rehab or therapy was it? (select all that apply)

☐ Physical therapy ☐ Chiropractic sports rehab ☐ Provider-directed home exercise program

What was your response to the rehab? (select one option)

☐ No benefit ☐ Mild benefit, but symptoms remain ☐ Moderate benefit, but symptoms remain

☐ Significant benefit, but symptoms remain ☐ All symptoms have resolved

Have you had any knee injections? ☐ No ☐ Yes

If yes, for each injection, please specify:

The date of injection_____

The injection location (into the knee joint, into a bursa, other area)_____

The type of injection: (corticosteroid, hyaluronic acid, anti-inflammatory, PRP, bone marrow aspirate concentrate, other, unknown) _____

The maximal percentage of pain (0-100%) that was improved

The duration of the improvement in pain

Date of injection:_____ location:_____ Type:_____ % Pain improved:____ Duration of relief:_____
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What imaging studies of your knee have already been obtained?

☐ None
☐ Radiographs within the past 3 months
☐ Radiographs greater than 3 months ago
☐ MRI within the past 3 months
☐ MRI greater than 3 months ago
☐ CT within the past 3 months
☐ CT greater than 3 months ago
☐ Bone scan within the past 3 months
☐ Bone scan greater than 3 months ago

Review Of Systems:

Constitutional:(select all that apply): ☐ Fever ☐ Chills ☐ Night sweats

HENT: ☐ Facial swelling ☐ Nosebleeds

Eyes: ☐ Visual disturbance

Cardiovascular: ☐ Chest pain ☐ Leg swelling

Respiratory: ☐ Shortness of breath ☐ Chest tightness

Gastrointestinal: ☐ Blood in stool ☐ Constipation ☐ Diarrhea

Genitourinary: ☐ Difficulty urinating ☐ Dysuria (pain when urinating) ☐ Flank pain ☐ Blood in urine

Musculoskeletal:

☐ Joint pain ☐ Back pain ☐ Difficulty walking ☐ Joint swelling ☐ Muscle pain ☐ Neck pain

Neurological: ☐ Dizziness ☐ Headaches ☐ Numbness ☐ Limb/muscle weakness

Hematologic: ☐ Bruising ☐ Easy bleeding

Psychological: ☐ Confusion ☐ Nervous/anxious ☐ Self-inflicted injury

Skin: ☐ Changes in skin color ☐ Rashes/lesions ☐ Open wounds

Allergic/Immunologic: ☐ Allergies to new medications/foods/clothing ☐ Hay fever

Endocrine: ☐ Increased urination or thirst ☐ Palpitations ☐ Weight loss or weight gain

Past Medical History:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical
- ☐ Dependence
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ DVT/PE/Blood Clots
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Malignant Hyperthermia
- ☐ Measles
- ☐ Migraine/Headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ S.T.D.
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Whooping Cough
- ☐ Other:
- ☐ No significant medical history

Past Surgical History:

- ☐ Appendectomy
- ☐ Biopsy:
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Heart Bypass (CABG)
- ☐ Gall Bladder Removal
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Gastric Bypass/Banding
- ☐ Hernia Repair
- ☐ Hip Arthroscopy
- ☐ Hip Replacement Surgery
- ☐ Hysterectomy
- ☐ Knee Arthroscopy
- ☐ Knee Replacement Surgery
- ☐ Kidney Stone Surgery (Lithotripsy)
- ☐ Ovary Removal
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Tonsil/Adenoid Surgery
- ☐ Valve Replacement Surgery
- ☐ Vasectomy
- ☐ Other:
- ☐ None

Family Medical History:

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children:_____

Alcohol consumption: ☐ None ☐ Yes

Glasses of wine per week:_____ ☐ Cans of beer per week:_____ ☐ Shots of liquor per week:_____

Tobacco use: ☐ None ☐ Yes

Current cigarette use: ____ ppd for ____ years Former cigarette use: ____ ppd for ____ years, quite date: _____

Other nicotine-containing products:_____

Allergies: Please allergies and reactions

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Medications:

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

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