Name: ______________________________ **Date:** ______________

Date of birth: ______________________________ **Age:** ______________

Referring doctor (if any): ______________________________

Why are you seeing the doctor?

____

____

How long has this problem existed? ______________________________

Is the problem a result of: ___ sports injury ___ work injury ___ accident ___ fall ___ other

please describe: ______________________________

Severity of pain: (circle) (1 - little pain; 10 - severe pain)

0 1 2 3 4 5 6 7 8 9 10

Primary Problem(s): (circle)

Pain Weakness Loss of Motion Stiffness Instability

Other (please describe): ______________________________

Which of the following symptoms you have experienced?: (circle)

Swelling Popping Locking / Catching Unable to Straighten Out Giving Way

Which of the following cause you pain?: (circle)

Sudden turns Squatting Kneeling Prolonged sitting

Ascending stairs Descending stairs Pain at rest Pain at night

Other: ______________________________

What have you done for this problem to date?	**Has it helped?**
Medicine: ______________________________	______________
Physical therapy: ______________________________	______________
Brace / Crutches / Cane / Walker: ______________________________	______________
Injections (steroid shot): ______________ How many? ______________	______________
Viscosupplementation (lubricant) injections: ______________	______________
Surgery: ______________________________	______________

All information in this Worksheet is **Confidential.**