



ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

KNEE FORM

Name: _____ Age: _____ Date: _____

Who referred you to the office? _____

Height: _____ Weight: _____

I am right-handed _____ Left-handed _____

Allergies: _____

Present Medications: _____

Which knee is bothering you: _____ right _____ left _____ both

Your major complaint is (check all that apply)

_____ aching pain _____ burning pain _____ stabbing pain _____ night pain
_____ deformity _____ loss of motion _____ loss of strength _____ swelling
_____ going out _____ locking _____ popping _____ grind
_____ other _____

Rate the severity of the problem: mild _____ moderate _____ severe _____

Nature of the onset of this problem: gradually _____ suddenly _____ reinjury of previous injury _____

What makes the problem better? _____

What makes the problem worse? _____

Have you tried: rest, ice, heat, braces, topical medications, or pills of any type? (circle all that apply)

Did they help? _____

Date of onset of this problem: _____

Describe your specific injury, if you had one: _____

Have you ever had any previous significant injury to this knee? _____

Have you had previous surgery on this knee? If so, when, what and by whom? _____

Range of motion if the knee?

_____ same as ever _____ unable to fully bend _____ unable to fully straighten

In what strenuous physical activities do you participate? Sports _____

Recreation _____ Work _____

In respect to your knee, have you _____ seen a doctor _____ had X-rays or MRI _____ had physical therapy?

Please rate your overall physical health?

_____ excellent _____ very good _____ good _____ fair _____ poor

Is this a legal or third party liability case?

_____ no _____ yes _____ motor vehicle accident _____ work comp _____ other

Do you have a lawyer and if so who? _____

Your e-mail address will be used as your
legal signature if submitted electronically.