INTAKE FORM

History

1: What is your complaint today? Right knee Left knee Bilateral knees Back Shoulder(s) Other:_____

2: When did the symptoms **begin**? _____ Days - Weeks - Months - Years

3: When did the symptoms **worsen**? _____ Days - Weeks - Months - Years

4: On a scale 0 – 10 (10 being the worst) please circle the number that best describes the symptom most of the time

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

5: Is the pain constant or intermittent? constant (meaning pain changes in severity but never completely goes away)

intermittent (pain comes and goes)

6: Please describe the quality of the symptoms: deep sharp dull achy burning throbbing piercing deep stabbing nagging shooting stiff other:_____

7: What makes the symptoms worse? nothing sitting standing walking lifting going from sitting to standing going up and down stairs lying down exercise bending twisting turning driving running working weight bearing activities other:_____

8: Are the symptoms worse at any particular time of day? morning afternoon evening night no difference

9: Have you seen anyone for this condition? If so, who/where? _____

10: What treatments have you previously tried? rest ice/heat massage NSAIDS/tylenol OTC knee brace/sleeve physical therapy chiropractics prescribed medication topical creams/ointments/oils stretching/exercise other:_____

10: Have you ever had a prescribed knee brace? If so, how long ago? _____ days months years

11: Have you ever had a steroid injection? If so, when was the last one? _____ days months years