Knee Pain Questionnaire

When did your pain start?--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

How did your pain start? Ie gradual, sudden, accident--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Can you describe your pain ie aching/burning ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Where is your pain? Does it radiate anywhere?--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine,

How do you rate your pain on your best day----------- your worst day----------

In the last 24 hours, how much relief have your pain treatments or medications provided?

Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete relief

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**1. General Activity:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Mood:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Walking Ability:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Normal Work (includes both work outside the home and housework)**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Relations with other people:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Sleep:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

1. **Enjoyment of Life:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Has your pain been getting better/worse/staying the same?----------------------------------------------- What makes your pain better stretching, resting exercising, medications?----------------------------------------------------------------------------------------------------------------------------------------------------------

What makes your pain worse?-----------------------------------------------------------------------------------

Is your pain constant or does it come and go?---------------------------------------------------------------

Does your knee swell?---------------------------------------------------------------------------------------------

Do you have stiffness in the morning or after sitting for a prolonged period?

Does your knee lock, click or catch?----------------------------------------------------------------------------

Does your knee ever give way?------------------------------------------------------------------------------------

Do you trust your knee?----------------------------------------------------------------------------------------------

Please circle if you have been experiencing any of the following:

Numbness or tingling in your legs Fever Weight loss

Change in bowel or bladder function Night Pain Chills

Loss of balance or Coordination Dizziness Loss of Hearing

Loss or Change in Vision Changes in Speech or Swallowing

Hot and swollen joints Sensitivity to sun rashes/psoriasis

Any others?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In terms of your function does your knee pain affect your

1. Ability to sit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Ability to walk?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Ability to stand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Ability to go up and down stairs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Ability to sleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Ability to work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Ability to participate in recreational activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried any of the following treatments? If so, were they successful?

Physiotherapy------------------------------------------------------------------------------------------------------------Chiropractor--------------------------------------------------------------------------------------------------------------Massage-------------------------------------------------------------------------------------------------------------------

Injections----------------------------------------------------------------------------------------------------------------

Medications--------------------------------------------------------------------------------------------------------------Surgery---------------------------------------------------------------------------------------------------------------------

Have you had any investigations for this problem? ie CT, x-ray, MRI. Where and when?------------------------------------------------------------------------------------------------------------------------------------------

Please tell me about any medical conditions you have---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------Please list any surgeries you have had in the past---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Please list your medications------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------Please list any drug allergies-----------------------------------------------------------------------------------------

Please tell me a bit about yourself...

What do you do/did you do for work?----------------------------------------------------------------------------

Do you do a regular exercise program? If so, what type of exercise and how frequently?-----------------------------------------------------------------------------------------------------------------------------------------

Are you a smoker Yes or No? Do you have a past history of smoking?------------------------------------How much alcohol would you drink in a week?-----------------------------------------------------------------

What are your hopes for today’s visit?----------------------------------------------------------------------------