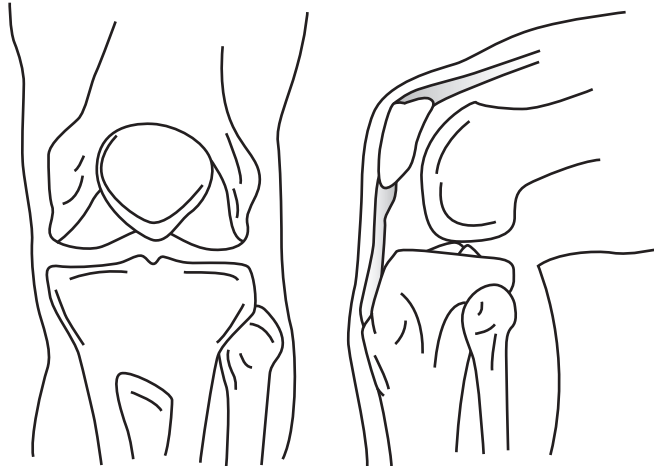


Name: \_\_\_\_\_

Date: MM / DD / YYYY

<b>IDENTIFYING THE PAIN</b>	Describe the injury/problem and past knee history			Please indicate the problem area with the following: XXXX Sharp Pain    //// Dull Ache    ---- Numbness or Tingling	
	Date of original injury MM / DD / YYYY	Which Knee <input type="checkbox"/> Right <input type="checkbox"/> Left	Which is Worse <input type="checkbox"/> Right <input type="checkbox"/> Left	 <p style="display: flex; justify-content: space-around;"><span>FRONT</span><span>SIDE</span></p>	
	Does your knee:				
Lock	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swell Immediately after injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grind	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swell Later	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pop	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swell Occasionally	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Give Way	<input type="checkbox"/> Yes <input type="checkbox"/> No				

<b>PAIN</b>	None, Mild, Non-Limiting	Right	Left
	Transient Limitation	<input type="checkbox"/> 15	<input type="checkbox"/> 15
	Vigorous Activity Mild Limitation	<input type="checkbox"/> 8	<input type="checkbox"/> 8
	Intermittent/Episodic Transient Limitation	<input type="checkbox"/> 12	<input type="checkbox"/> 12
	Constant/Frequent Severe Limitation	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Other: _____	<input type="checkbox"/> 0	<input type="checkbox"/> 0

<b>WALKING</b>	Unlimited	Right	Left
	Smooth Surface Okay	<input type="checkbox"/> 10	<input type="checkbox"/> 10
	Limited by Pain &/or Instability on Any Surface	<input type="checkbox"/> 7	<input type="checkbox"/> 7
	Requires Support (Cane, Brace, Etc.)	<input type="checkbox"/> 4	<input type="checkbox"/> 4
		<input type="checkbox"/> 0	<input type="checkbox"/> 0

<b>LIMITATION</b>	None	Right	Left
	Mild - No Handicap	<input type="checkbox"/> 10	<input type="checkbox"/> 10
	Severe - Definite Handicap	<input type="checkbox"/> 7	<input type="checkbox"/> 7
	Limited/Other: _____	<input type="checkbox"/> 0	<input type="checkbox"/> 0

<b>RUNNING</b>	Unlimited	Right	Left
	Speed Caution	<input type="checkbox"/> 10	<input type="checkbox"/> 10
	Trouble Changing Direction	<input type="checkbox"/> 8	<input type="checkbox"/> 8
	Unable	<input type="checkbox"/> 4	<input type="checkbox"/> 4

<b>SWELLING</b>	None	Right	Left
	Activity Related Only	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	Occasional	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Frequent	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	Chronic	<input type="checkbox"/> 1	<input type="checkbox"/> 1

<b>STAIRS/INCLINES</b>	No Difficulty	Right	Left
	Mild Difficulty	<input type="checkbox"/> 10	<input type="checkbox"/> 10
	Moderate Difficulty (one step at a time)	<input type="checkbox"/> 8	<input type="checkbox"/> 8
	Unable	<input type="checkbox"/> 4	<input type="checkbox"/> 4

<b>INSTABILITY</b>	None	Right	Left
	Slight - No Reaction	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	Mild - Some Disability	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Moderate - Definite Limitation	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	Severe - Market Limitation	<input type="checkbox"/> 1	<input type="checkbox"/> 1

<b>JUMPING</b>	No Difficulty	Right	Left
	Difficulty	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	Unable	<input type="checkbox"/> 3	<input type="checkbox"/> 3

<b>WORK/ACTIVITY</b>	Unlimited	Right	Left
	Mild Limitation	<input type="checkbox"/> 15	<input type="checkbox"/> 15
	Moderate Limitation	<input type="checkbox"/> 12	<input type="checkbox"/> 12
	Severe Limitation	<input type="checkbox"/> 8	<input type="checkbox"/> 8
	Unable	<input type="checkbox"/> 5	<input type="checkbox"/> 5

<b>TOTALS</b>	Right: _____	Left: _____
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