Knee Exam

(405)-732-7777

Name:_________________________________ Age: ___Today's Date:__________

Which nee is the problem: L / R

What is the main problem with your knee? ________________________________

Rate your pain 1-10:____________

Where exactly does your knee hurt? Right Side:___Left Side:___ Front: ___Back:___

Does your pain go somewhere else? Yes________No____ Where?_____________

What date did it start?_______________How did it start?_____________________

What makes problem worst?____

____

What makes problem better?____

____

Does your knee also: buckle:___ lock:___swell:___

How often have these occurred____

Are any of these symptoms connected to your knee problem? Back pain:___
Groin Pain:___Lateral Hip Pain:___Numbness:___Weakness:___

What are you main limitations? Sit to Stand:___Pain:___Stairs:___ Walking:___

What test have you had so far? X-ray:___CT Scan: ___MRI:___Emg:____

Where were these test performed?____

What treatment have you had so far? Rest: ___Injection:___NSAIDS:___
Physical Therapy:____Surgery:___IF yes When?__________________________

What was done____

Have you had problems before with the knees? Yes No When?____

How much manual labor do you? ____

What sports do you do consistently?____________________At what level?_______________________________

What are your goals for treatment? ____

DX:_____________________________

RX: _____________________________

	R	L
ROM:	___	___
EFFUSION:	___	___
CREPITATION:	___	___
PAIN c PF GRIND:	___	___
PATELLAR TRACKING:	___	___
PAIN C PALPATATION:	___	___
VARUS:	___	___
VALGUS:	___	___
ANT DRAWER:	___	___
POST DRAWER:	___	___
PIVOT SHIFT:	___	___
POST SHIFT:	___	___
MCMURRY:	___	___
WB MCMURRY:	___	___
SQUAT:	___	___
X-RAY:	___	___
MRI:	___	___