PT NAME_____

# HISTORY FORM/ KNEE

## Please circle below the answers to the following questions

Right knee/ Left knee How long have you had this problem?_____

Where does your knee hurt (inside of knee / outside of knee / back of knee ) _____

Does the pain move anywhere else? yes / no Where?_____

Describe the Pain (burning / sharp / dull / aching / stabbing) _____

Is the pain constant / come and go?_____

Does anything make the pain worse? Sitting / standing / lying down / stairs_____

Does anything make the pain better? Sitting / standing / lying down_____

Is there any (locking / popping / swelling / giving out of the knee / catching)?_____

Please add any additional information below that would be important for the Doctor to know below_____