PHYSICIANS REHABILITATION
SPECIALIZING IN BACK, NECK & KNEE PAIN

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Knee Joint Pain Questionaire

Name:_____ **DOB:**_____

*Pain for the purposes of this form can be defined as any uncomfortable sensation or discomfort that you experience and can describe including, but not limited to stinging, burning, itching, aching, fullness, stabbing, cramping, or tension

1. Have you had pain in your knee(s) in the last three years? (If YES, indicate left, right or both)

   Yes - ☐ Left ☐ Right ☐Both No_____

2. Do you have a known diagnosis of osteoarthritis by healthcare professional?

   Yes_____ No_____

3. Does your knee pain/osteoarthritis interfere with your daily living, activities, or plain enjoyment?

   Yes_____ No_____

   If YES, please mark all that apply:

   Pain that gives you discomfort during important activities or interupts your sleep:

   ___ dancing
   ___ socializing
   ____ standing
   ____sleeping
   ____grinding or popping noises of your knee joint
   ____knee joint stiffness, fullness, tightness
   ____decreased activity or inactivity
   ____Other_____

4. Have you ever been told that you have “bone on bone” in your knee(s) by Xrays or MRI?

   Yes_____ No_____

5. Have you ever used any of the following therapies in a reasonable effort, either intermittently or sustained, to obtain relief from your knee pain or osteoarthritis?

   Yes_____ No_____

   If YES, please indicate all that apply:

   ____NSAIDS (Aspirin, Motrin/ibuprofen, Aleve/naproxen
   ____Acetaminophen/Tylenol
   ____physical therapy
   ____home exercise (walking, swimming, bicycle, etc.)
   ____education
   ____weight loss or dieting

More questions on the next page →

6. Have you ever had a knee injection with corticosteroids i.e. cortisone or had your knee drained of fluid by a needle?

   Yes_____ No_____

7. Do you have any other diseases of the knee joints or bones?

   Yes_____ No_____

   If YES, check all that apply:

   ____Rheumatoid arthritis,

   ____Psoriatic arthritis,

   ____Cancer either primary or metastatic to bone

   ____other (Explain)_____

8. Have you ever had arthroscopy ("knee scope") of your knee(s)?

   Yes_____ No_____

9. Have you had previous Hyaluronidate visco-supplementation therapy (VST) in your knee?

   Yes_____ No_____

   IF YES, check any that apply and answer the follow up questions below:

   ☐ Orthovisc ☐ Synvisc ☐ Supartz ☐ Euflexxa ☐ Hyalgan

   Was this VST helpful in any way?

   Yes_____ No_____

   Did you do so in conjunction with a formal Physical Therapy program?

   Yes_____ No_____

10. Are you allergy or side effect to medicines that are available over-the-counter for pain such as Aspirin, Motrin/Ibuprofen, Aleve/Naproxen, Acetaminophen/Tylenol?

    Yes_____ No_____

11. Is the painful/arthritic knee(s) you are seeking treatment for partial or full artificial knee replacement?

    Yes_____ No_____