HEALTH
UNIVERSITY OF UTAH

Referring Physician: _____
Primary Care Provider: _____
Height: _____Weight: _____
Age: _____Gender: _____

What is your main complaint today? _____
How long have you had this complaint/issue? _____

What area(s) of your body have pain/discomfort? (check all that apply)

KNEE	**right knee**	**left knee**	**HIP**	**right hip**	**left hip**
anterior (front)	☐	☐	anterior (front)	☐	☐
posterior (back)	☐	☐	posterior (back)	☐	☐
medial (inside)	☐	☐	medial (inside)	☐	☐
lateral (outside)	☐	☐	lateral (outside)	☐	☐

The pain is associated with: (circle all that apply)

Pain	Deformity	Instability
Giving away	Numbness	Tingling
Swelling	Stiffness	Catching
Locking	Grinding	Redness
Increased skin temp	Weakness	Bruising
Open sore	Draining wound	Inability to bear weight

The type of pain is: (circle all that apply)

Burning	Dull	Shooting	Stabbing
Clicking	Popping	Snapping	throbbing

Circle one number that best describes your level of pain: (0= no pain 10= worst pain ever)

0	1	2	3	4	5	6	7	8	9	10

Does your pain radiate? Yes No **If so to where?** _____

What activities make your pain worse? (circle all that apply)

Standing	Sitting	Laying
Walking	Running	Jumping
Driving	Working	Stairs
Hills	Repetitive activities	Lifting
Grasping	Overhead activities	Hard pivots
Quick starts	Hard stops	Other-_____

What makes your pain better? _____

When is the pain present? (circle all that apply)

Constantly Intermittently Daily Weekly Monthly Rarely

When is the pain worse? (circle all that apply)

Morning Day Night Wakes me up/Sleeping

Progression of the pain: (circle all that apply)

Unchanged	Gradually improving	Gradually worsening	Rapidly improving	Rapidly worsening	Waxing and waning

Please proceed to the next page

Non-surgical treatments tried: (circle all that apply)

Acetaminophen	Ice	Physical therapy
NSAIDS	Stretching	Massage therapy
Oral narcotics	Compressive wrap	Steroid injections
Rest	Bracing	Assistance device
Activity modification	Anesthetic	Other- _____
Elevation	viscosupplementation	

Which NSAIDS tried? _____ Narcotics? _____

Date of recent steroid injection: _____ Date of Viscosupplementation: _____

Previous physical therapy: (circle all that apply)

Home therapy	TENS/muscle stimulation	Heat
Supervised therapy	Ultrasound	Whirlpool
Strengthening exercises	Stretching exercises	Deep massage
ROM exercises	Ice	Chiropractic manipulation

How long did you try therapy for? _____

Beneficial non-surgical treatments: (circle all that apply)

Activity modification	Compression support	Weight loss
Narcotics	Exercise	Injection
NSAIDS	Supervised therapy	Walking aid

Assistive devices used: Cane Walker Crutch Wheelchair

Is your pain injury related? _____

Have you had previous operative treatment in this region? _____

If so what type? (IE type of surgery, where and when) _____

_____

Do you have other problems in this region? _____

Has another provider treated you for this problem? _____

If so who? _____

Surgical History- List all surgeries and dates

Surgery	Date	Surgery	Date

Any know allergies to anesthesia? _____ **if so describe:** _____

Medications: Please list all medications or bring your own list

Medication	Dose	Medication	Dose

Allergies to medication: _____