Orthopedics

Sticker

HIP AND KNEE INTAKE FORM

What are we seeing you for today (check all that apply)?

☐ Right knee ☐ Left knee ☐ Right hip ☐ Left hip

Who can we thank for referring you? ☐ Self-referred ☐Primary Care Provider:_____

☐ Family or Friend _____ ☐ Other_____

Are you interested in? ☐ Non-surgical options ☐ Surgical options ☐ I'd like information on both

When did you first notice the pain (approximately)?_____

Pain Location: ☐ Front of knee ☐ Back of knee ☐ Side of knee ☐ Shin

☐Groin ☐Buttock ☐ Side of hip ☐ Low back ☐ Thigh

Rate the worst pain you experience in your hip or knee on a typical day::
(Circle one number)

Which best describes your pain? (Check all that apply):

☐Sharp ☐Dull ☐Shooting ☐Throbbing ☐ Electrical feeling

How far can you walk before pain stops you? ☐Less than 1 block ☐5 blocks ☐1 Mile ☐ No Limit

Aggravating Factors – What makes it worse?_____

Alleviating Factors – What makes it better?_____

Non-operative treatments in the past year (For *this specific problem*, check all that apply):

☐Brace	☐Naproxen (Aleve)	☐Cane/Crutch/Walker	☐Synvisc or other "gel" injection
☐ Cortisone injection	☐Ibuprofen (Advil/Motrin)	☐Chiropractor	☐Stem cell injection
	☐Acetaminophen (Tylenol)	☐ Physical therapy	☐PRP injection

☐Prescription Pain Medicine: _____

What is your Occupation?_____ ☐Retired ☐Disabled ☐Unemployed

Are you on blood thinners? ☐Yes ☐No **If YES – which one(s)?** _____

Have you ever had a blood clot in your arms, legs, or lungs? ☐Yes ☐No **If YES – date?** _____

Do you have numbness or tingling in your legs or feet? ☐Yes ☐No If yes, where?_____

When you are active, exercise, or go up stairs do you have:

Chest pain? ☐Yes ☐No **Shortness of breath?** ☐Yes ☐No