CARRELL CLINIC

HIP/KNEE EVALUATION FORM

Patient Name: _____ **Date**: _____

Age: _____ **y/o** **Sex**: M F **Occupation**: _____

Vitals: Ht _____ Wt _____ T _____ HR _____ RR _____ BP ____ /____

☐ **Knee** ☐ **Hip** Involved: ☐ R ☐ L ☐ Both **Onset Date:**_____

Type of Symptoms: ☐ Clicking ☐ Popping ☐ Catching ☐ Locking
☐ Stiffness ☐ Weakness ☐ Instability

Duration of Problem: 1 2 3 4 5 6 7 8 9 10 11 12 Days Wks Mos Yrs

Specific Injury: ☐ Yes ☐ No If yes, please describe your injury: _____

_____

Location of Pain: ☐ Front ☐ Back ☐ Side ☐ Inside ☐ Outside

Pain is Worsened by: ☐ Sudden Turns ☐ Squats ☐ Kneeling
☐ Prolonged Sitting ☐ Upstairs ☐ Downstairs

Severity of Pain: ☐ Mild ☐ Moderate ☐ Severe

Pain Level: ←——————————————→
0 1 2 3 4 5 6 7 8 9 10

Frequency of Pain: ☐ Intermittently ☐ Constant

Pain at Night? ☐ Yes ☐ No **Pain at Rest?** ☐ Yes ☐ No

Walking tolerance is approximately: _____ blocks

Prior Treatment:

Previous Surgery	☐ Y	☐ N	Type & Date:_____			
Ice:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Anti-Inflammatory:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Cortisone Injection:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Gel Injection:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Physical Therapy:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Home Exercise:	☐ Y	☐ N	Relief:	None	Minimal	Substantial
Cane or Walker:	☐ Y	☐ N	Relief:	None	Minimal	Substantial

Prior Evaluation:

X-RAY: ☐ Y ☐ N Results: _____

MRI: ☐ Y ☐ N Results: _____