GP THERAPY, LLC **D.B.A.**
GERMANTOWN PHYSICALTHERAPY
Telephone 301-916-0164 Facsimile 301-540-0722

Patient: _____ Region: Knee

1. Describe your pain (sharp, dull, radiating, etc)_____
2. When and how did it start?_____
3. What makes it better? Worse?_____
4. Have you had other treatment for this condition? If so, what kind?_____
   _____
5. Rate your average pain intensity over the past week on the 0 to 10 scale with 10 being the worst pain imaginable. _____/10
6. Average number of times you wake per night due to **knee** pain. _____
7. Standing tolerance is _____ minutes.
8. Walking tolerance is _____ minutes.
9. Are you using an assistive device such as a cane or crutches? _____

For questions 10 through 19, circle the number that best describes your level of difficulty with the following activities. 0 indicates no difficulty, whereas 10 indicates the inability to perform the activity at all.

	No Difficulty										**Extreme Difficulty**
10. Driving a car	0	1	2	3	4	5	6	7	8	9	10
11. Getting in/out of car	0	1	2	3	4	5	6	7	8	9	10
12. Walking up stairs	0	1	2	3	4	5	6	7	8	9	10
13. Walking down stairs	0	1	2	3	4	5	6	7	8	9	10
14. Walking uphill	0	1	2	3	4	5	6	7	8	9	10
15. Walking downhill	0	1	2	3	4	5	6	7	8	9	10
16. Stepping down from a curb	0	1	2	3	4	5	6	7	8	9	10
17. Coming to stand from sitting	0	1	2	3	4	5	6	7	8	9	10
18. Squatting	0	1	2	3	4	5	6	7	8	9	10
19. Kneeling	0	1	2	3	4	5	6	7	8	9	10
20. Running	0	1	2	3	4	5	6	7	8	9	10
21. Jumping	0	1	2	3	4	5	6	7	8	9	10

22. What is your current occupation?_____
23. Does your pain affect your occupation? If so, how?_____
    _____
24. Does your pain affect home life? If so, how?_____
    _____
25. Does your pain affect your recreation/leisure/sports? If so, how? _____
    _____

Patient's Signature: Date: / /