



LOWER EXTREMITY

Name _____ Preferred name _____

Date of birth ___/___/___ Age ___ Sex: M / F Occupation _____

Referring physician _____ Primary care physician _____

Most recent medical exam ___/___/___ Next exam ___/___/___

For this condition, have you seen any other medical providers? Y / N – please list _____

MEDICAL HISTORY

- Arthritis (Osteoarthritis Rheumatoid)
 - Fibromyalgia Other)
 - Osteoporosis / Osteopenia
 - Asthma
 - Chronic obstructive pulmonary disease (COPD)
 - Respiratory distress syndrome (ARDS)
 - Emphysema Chronic bronchitis
 - Angina or Irregular heartbeat
 - Congestive heart failure or heart disease
 - Heart attack (myocardial infarction)
 - High blood pressure
 - Neurological disease
 - (Such as multiple sclerosis Parkinson's)
 - Stroke or TIA
 - Peripheral Vascular Disease
 - Headaches
 - Diabetes (Type I / Type II)
 - Previous accidents (explain/ give dates below)
 - Visual impairment (cataract glaucoma macular degeneration)
 - Hearing impairment (hard of hearing hearing aids)
 - Back pain (neck pain low back pain
 - degenerative disc disease spinal stenosis)
 - Kidney, bladder, prostate, urination problems
 - Incontinence
 - Hypothyroid / Hyperthyroid
 - Allergies: _____
 - Anxiety panic disorders depression other disorders
 - Hepatitis / AIDS
 - Prior surgery (list below)
 - Prosthesis / Implants
 - Sleep dysfunction
 - Cancer (Type _____)
 - Gastrointestinal disease (ulcer hernia
 - reflux bowel liver gall bladder)
 - Gynecologic problems. (#children ___ #pregnancies ___)
- Please clarify any checked items above and provide other medical information _____

List surgeries/dates _____

Family medical problems _____

Last eye exam: _____ What is your hand dominance? Right Left

Smoking - # pack(s)/day _____ Alcohol - # drink(s)/day _____ Other substance use _____

Have you recently experienced?

- Unexplained weight loss / gain
- Shortness of breath
- Illness / flu / virus
- Headaches
- Feeling unsteady or fear of falling
- Changes in appetite
- Fever / chills / sweats
- Nausea / vomiting
- Night pain
- Dizziness when getting up from resting flat
- Changes in bowel / bladder function
- Sexual difficulty
- Dizziness / fainting
- Falls in the past year (number _____)

MEDICATIONS (include over-the-counter) I have a list of medications, and have attached it to this form

Drug name	Dosage	How often	Pill/liquid/ Spray/injection	Condition	New (Y/N)

MEDICAL TESTING (List tests related to your current problem – dates: actual or as closely as possible)

	Date performed	Facility where performed	Your understanding of results
<input type="checkbox"/> X-ray	_____	_____	_____
<input type="checkbox"/> MRI <input type="checkbox"/> CT Scan	_____	_____	_____
<input type="checkbox"/> Blood/Urine	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

ACTIVITIES: mark those you are currently active with and how many times/week

- Walking Running Bicycling Weights Swimming Exercise class _____
Golf Tennis Basketball Skiing Soccer Gardening Other _____

How many days/week? _____ Duration each day _____

This is a statement other patients have made. *"I should not do physical activities which (might) make my pain worse."* Please rate your level of agreement with this statement below. (Response)

- Completely agree Somewhat agree Unsure Somewhat Disagree Completely Disagree

CURRENT PROBLEM/REASON YOU ARE HERE:

Describe in your own words _____

ONSET:

0-7 days 8-14 days 15-21 days 22-90 days 91 days – 6 months > 6 months Date: _____

Did it begin suddenly or gradually what, if known, caused your problem? _____

Is your problem getting better worse not changing?

Just before your problem began, were you completely free of discomfort or problems with the area? Y / N
Describe prior episodes including date(s), cause, duration and treatments

PAIN RATING *right now* (Circle below)

0 1 2 3 4 5 6 7 8 9 10
 No pain worst imaginable pain

0-10 pain over the **past two weeks** when at its best/lowest: _____ / 10 worst/highest: _____ / 10

DESCRIPTION OF DISCOMFORT:

- Ache Pain Sharp Dull Pins/needles Tingling Numbness
Burning Throbbing Cramping Swelling Other _____

Is your problem/discomfort Constant Intermittent – if so, how often/how long lasting _____

How long can you be symptom free _____ Does coughing or sneezing cause discomfort? Y / N

Does the time of day affect your problem? Y / N When is it better? _____ Worse _____

How does rest affect your problem? Relieves Makes worse No change

What activities/positions aggravate your problem? _____

What activity/positions relieve/decrease your problem? _____

Does discomfort ever awaken you at night? Y / N If yes, # times/night _____ Can you return to sleep? Y / N

Have you had previous physical therapy for this problem? Y / N what was the outcome? _____

Please let us know your goals/expectations: _____

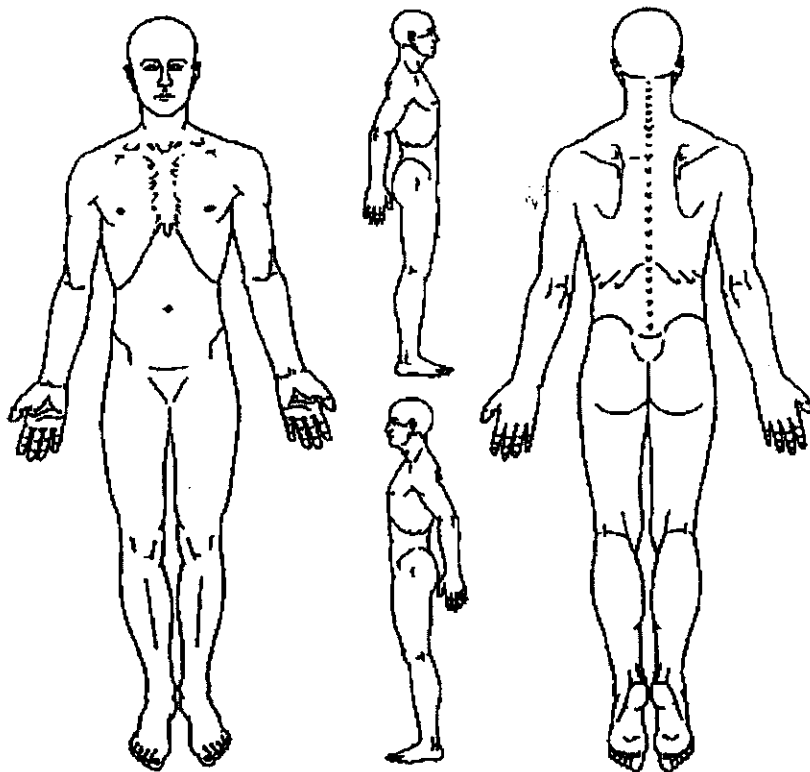
LOCATION OF SYMPTOMS:

When your problem began, was your discomfort in exactly the same location as you have it now? Y / N

If the position of the discomfort has changed, how did it progress from the original location?

Please mark on the body diagram below (with the designated signs) exactly where your current problem is

- ✓ Minimal to moderate pain
- ➔ Radiating pain
- Severe pain
- XX Numbness



Office use only				
BP _____	HR _____	Height _____	Weight _____	BMI _____

**KOS FORM
KNEE OUTCOME SURVEY**

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

NAME: _____ **DATE OF BIRTH:** (MM/DD/YYYY) _____

DID YOU HAVE SURGERY FOR THIS ISSUE PRIOR TO RECEIVING THERAPY? YES NO

PAIN SCORE: OVER THE PAST 24 HOURS, HOW BAD HAS YOUR PAIN BEEN?
CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR PAIN.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST IMAGINABLE PAIN

TO WHAT DEGREE DOES EACH OF THE FOLLOWING SYMPTOMS AFFECT YOUR LEVEL OF ACTIVITY?
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	I DO NOT HAVE THIS SYMPTOM	I HAVE THE SYMPTOM, BUT IT DOES NOT AFFECT MY ACTIVITY	THE SYMPTOM AFFECTS MY ACTIVITY SLIGHTLY	THE SYMPTOM AFFECTS MY ACTIVITY MODERATELY	THE SYMPTOM AFFECTS MY ACTIVITY SEVERELY	THE SYMPTOM PREVENTS ME FROM ALL DAILY ACTIVITY
1. PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. STIFFNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. KNEE GIVES WAY: BUCKLING OR SHIFTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. LIMPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**KOS FORM
KNEE OUTCOME SURVEY**

FUNCTIONAL LIMITATIONS WITH ACTIVITIES - HOW DOES YOUR KNEE AFFECT YOUR ABILITY TO:
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	ACTIVITY IS NOT DIFFICULT	ACTIVITY IS MINIMALLY DIFFICULT	ACTIVITY IS SOMEWHAT DIFFICULT	ACTIVITY IS FAIRLY DIFFICULT	ACTIVITY IS VERY DIFFICULT	I AM UNABLE TO DO THE ACTIVITY
7. WALK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. GO UP STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. GO DOWN STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. STAND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. KNEEL ON FRONT OF YOUR KNEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. SQUAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. SIT WITH YOUR KNEE BENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. RISE FROM A CHAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>