

Knee Pain Questionnaire

Which knee is bothering you? Right Left Both

Did your knee pain start with a specific injury? Yes No

If yes: Date of injury: _____

Mechanism of injury _____

Did you feel a pop or snap with the injury? Yes No

Is the injury work related? Yes No

Did your pain start with a particular sport or activity? Yes No

If yes, what started the pain? _____

If there was no injury, when did the pain start? _____

What part of your knee hurts? Front Inside Outside Back

What are your primary sports and/or activities? _____

How would you describe your pain? (constant, intermittent, mild, severe, etc.)

Do any of the following increase your pain?

Prolonged walking: Yes Minimally No

Prolonged standing: Yes Minimally No

Going up or down stairs: Yes Minimally No

Prolonged sitting: Yes Minimally No

Getting up from a sitting position: Yes Minimally No

Kneeling or squatting: Yes Minimally No

Pivoting or twisting motions: Yes Minimally No

Is there anything else that increases your pain? _____

Do any of the following decrease your pain?

Rest: Yes Minimally No

Ice: Yes Minimally No

Heat: Yes Minimally No

Over the counter medicines (Tylenol/Advil) Yes Minimally No

Prescription pain medicines: Yes Minimally No

Is there anything else that decreases your pain? _____
