Alta Orthopaedics Hip/Knee Evaluation

Name:____ **Date:**_________________

My major complaint is: (Please circle) **pain / swelling / loss of motion / giving out / locking / grinding**

How did this problem begin? (Please circle) **gradually / suddenly / at work / vehicle accident / sports**

(Please specify)____

Do you feel your symptoms: (Please circle) **are improved / are more severe / are the same**

The primary location of pain is: (Please circle) **front / back / inner side / outer side / deep inside**

Do you hurt anywhere else? (Please specify)____

When does the affected part hurt? (Please circle) **infrequently / when active / constantly**

Other:____

What makes the pain worse? (Please circle) **sitting / standing / getting up / walking / stairs / exercise**

Other:____

The pain is relieved by: (Please circle) **nothing / rest / heat / cold / activity / medicine, what kind?**__________

Does your hip/knee hurt while sitting? (Please circle) **yes / no**

Does the pain wake you at night? (Please circle) **yes / no**

Is the hip/knee ever swollen? (Please circle below)
Infrequently / constantly / only after activity / only at time of injury

Does the hip/knee lock or get stuck? (Please circle) **rarely / occasionally / continually / at first, but not now**

Does the knee give out or buckle? (Please circle below)
Entire knee shifts / kneecap shifts / something inside shifts

How is the motion in the hip/knee? (Please circle) **same as ever / can't fully straighten / can't fully bend**

Walking ability: (Please circle) **normal / with a limp / use a walking aid / can't walk**

Type of walking aid being used: (Please circle) **cane / crutches / walker / brace / wheelchair**

How long are you able to walk? (Please circle) **60 minutes or more / 10 minutes / less than 5 minutes**