

		X-Ray
R	L	Finger: _____
R	L	Hand
R	L	Wrist (AP, Lat, Oblique)
R	L	Elbow (AP, Lat, Oblique)
R	L	Shoulder (AP, Grash, AX Scap Y)
R	L	Hip (<input type="checkbox"/> with AP Pelvis)
R	L	Knee (Stand AP, Lat Sunrise)
R	L	Ankle (AP, Lat, Mortise)
R	L	Foot (AP, Lat, Oblique)
		Other: _____

Knee Assessment

Patient's Name: _____ Occupation: _____

Involved Knee: **RIGHT LEFT BOTH** Was there an injury? **YES NO**

Date of Injury _____ Did the injury occur at work? **YES NO**

Describe what happened to your knee:

Primary Care Doctor's Name _____

Who Referred You To Us? _____

Circle problems with your knee.			
Location:	Kneecap	Inner Joint (medial)	Outer Joint (lateral) Back of knee
Quality:	Aching Boring Pins/Needles Sharp Sore Stabbing Stinging Throbbing	Other: _____	
Severity:	Mild Moderate Severe		
Rate the Pain:	(No pain) 0---1---2---3---4---5---6---7---8---9---10 (Severe pain)		
Functional Impairment:	Mild Mild-Moderate Moderate Severe/Disabling		
Are you currently in pain?	Yes No	When did it start?	Days___ Weeks___ Months___ Years___
Aggravating Factors:	Climbing stairs Running Squatting Sports	Other _____	
Relieving Factors:	Cold Heat Massage	Other: _____	
Previous Treatment:	Injections: Yes No Medications _____ OTC _____	Surgeries _____	
Joint Symptoms:	Grinding Giving Away Instability Locking Looseness Loss of Motion Popping Swelling	Tender to Touch Other _____	

* Dr. Thompson and Dr. Galluch are investors in Ohio Valley Medical Center. At times they refer patients to Ohio Valley Medical Center in connection with their care and treatment.