Dr Matt Lyons

Date of Consultation:_____

KNEE INJURY ASSESSMENT FORM

Name:_____

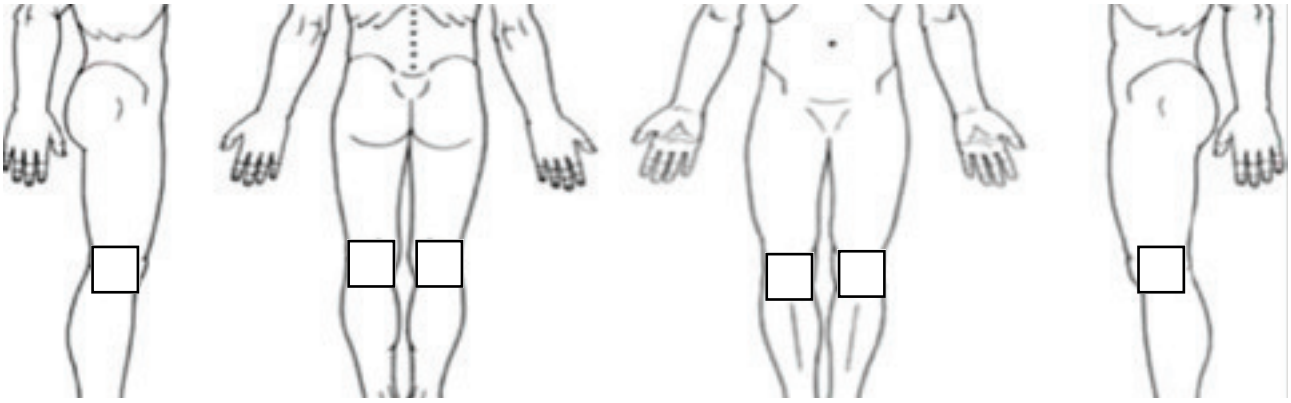
Height:_____

Occupation:_____

Weight:_____

Which knee is affected? (Please circle) ☐RIGHT / LEFT☐
If both, which is worse? ☐RIGHT / LEFT☐

Please mark on the image where pain is experienced?



How long has your knee been bothering you?_____
If applicable, how did you injure your knee?_____

What are the main issues and restrictions you have experienced?_____

What symptoms have troubled you in the past 2 weeks?

☐ Swelling
☐ Grinding
☐ Catching
☐ Difficulty sleeping

☐ Pain
☐ Instability
☐ Locking
☐ Stiffness

☐ Difficulty squatting
☐ Difficulty going up stairs
☐ Difficulty going down stairs
Other:_____

What treatments have you had for your knee?

☐ Pain killers
☐ Anti-Inflammatories

☐ Physiotherapy
☐ Surgery

☐ Injections
Other:_____

If you have had previous surgery, please list surgeon, procedure and date of surgery:

_____

Have you injured your knee in the past? If yes, please describe:_____

_____

What activities do you wish to resume after your treatment?_____

_____

What are your expectations from todays consultation?_____

_____