

THERAPRACTICS

KNEE EVALUATION



PATIENT: _____ DATE: _____

PATIENT#: _____ EMPLOYER: _____

DIAGNOSIS: _____ PHYSICIAN: _____

SUBJECTIVE HISTORY

AGE: _____ D.O.B.: _____ SEX: _____ OCCUPATION: _____ DATE OF INJURY: _____

MECHANISM OF INJURY: _____

GENERAL HEALTH: _____

PERTINENT SURGERIES / DATES: _____

MEDICATIONS: _____

PREVIOUS HISTORY / TREATMENT: _____

CHIEF COMPLAINT: _____

PAIN (0 – 10, 0 = NO PAIN): _____

OBJECTIVE

Range of Motion:	RIGHT	LEFT
Straight Leg Raise (SLR)	°	°
Knee Motion 0 - 145° (Active/Passive)	/	/
Q Angle		
Strength: Psoas	/5	/5
Flexion	/5	/5
Extension	/5	/5
Girth:		
" Above Suprapatellar Border		
Mid Patellar Border		
" Below Infrapatellar Border		

CLINICAL OBSERVATION (Swelling, redness, drainage / open areas, etc.) _____

PALPATION: _____

SPECIAL TESTS:

	LEFT	RIGHT		LEFT	RIGHT
ANTERIOR DRAWER	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	VALGUS STRESS	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
POSTERIOR DRAWER	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	VARUS STRESS	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
McMURRAY'S	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	PATELLAR COMPRESSION	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> Neg <input type="checkbox"/> Pos

MAJOR PROBLEMS: 1. Pain Swelling Spasm _____

2. Decreased: ROM/Flexibility _____ Strength _____

3. Postural Deficits _____

GOALS: 1. Decrease: Pain Swelling Spasm _____

2. Increase: ROM/Flexibility _____ Strength _____

3. Improve Posture _____

PLAN: 1. Therapeutic Exercises _____

2. Soft Tissue Mobilization Joint Mobilization _____

3. Modalities PRN for: Pain Swelling Spasm control _____

FREQUENCY: _____ DURATION: _____

R.P.T., D.C.