

WILLIAM K. MONTGOMERY M.D. P.A.

PATIENT ASSESSMENT AND TREATMENT OUTCOMES

Name: _____ Date: _____

1) How much pain do you have in your hip or knee?

HIP		KNEE
R L	No pain	R L
R L	Slight , occasional, no compromise in activity	R L
R L	Mild , effects ordinary activity, pain after stairs or unusual activity, use Tylenol	R L
R L	Moderate , tolerable, limit activities, use of anti-inflammatory medication	R L
R L	Marked , serious limitations, continual	R L
R L	Severe or totally disabled	R L

2) When does your hip or knee pain bother you?

HIP		KNEE
R L	No Pain	R L
R L	Pain with standing	R L
R L	Pain with first steps which goes away	R L
R L	Pain only after long walks	R L
R L	Pain with all walking activity	R L
R L	Pain at all times	R L

3) How often does hip or knee pain limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

4) How often does stiffness, limited motion or weakness in your hip or knee limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

5) How much does your hip or knee limit your ability to do sports or physical recreation?

- { } No limitations
- { } Slightly limits me
- { } Moderately limits me
- { } Greatly limits me
- { } Totally limits me

6) How often has your hip or your knee interfered with your ability to get together with friends or relatives?

- { } All of the time
- { } Most of the time
- { } Some of the time
- { } None of the time

7) How much does your hip or knee limit your ability to work?

HIP		KNEE
R L	No limitations	R L
R L	Slightly limits me	R L
R L	Moderately limits me	R L
R L	Greatly limits me	R L
R L	Totally limits me	R L
{ }	Not working for other reasons	

8) Work capacity for the past three months:

- { } Retired
- { } 25%
- { } 50%
- { } 75%
- { } 100%
- { } Works through the pain

9) What level of activity are you routinely doing?

- { } Bedridden or confined to a wheelchair, need assisted care
- { } Sedentary - minimum capacity for walking or other activity, low level activities of daily living (stairs, carrying, lifting, stooping)
- { } Semi-sedentary - white collar job, bench work, light housekeeping, indoor activities of daily living (stairs, carrying, lifting, stooping)
- { } Outdoor activities: occasional low stress sports, (golf, swimming, biking)
- { } Moderate manual labor.
- { } Heavy manual labor, high stress sports (racquet sports, basketball, baseball, skiing, tennis, running)

<p>10) Do you need support when walking?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what kind?</p> <p><input type="checkbox"/> Cane</p> <p><input type="checkbox"/> Walker</p> <p><input type="checkbox"/> Unloader brace</p> <p><input type="checkbox"/> Wheelchair</p>	<p>11) I experience PAIN at what distance :</p> <p><input type="checkbox"/> 1 mile or greater</p> <p><input type="checkbox"/> 6-10 blocks or > 1/2 to < 1 mile</p> <p><input type="checkbox"/> 1-5 blocks or 1/4 to 1/2 mile</p> <p><input type="checkbox"/> 1 block</p> <p><input type="checkbox"/> Less than 1 block</p>
<p>12) I experience PAIN at what time after getting up to stand or walk:</p> <p><input type="checkbox"/> 31 - 60 minutes</p> <p><input type="checkbox"/> 11 - 30 minutes</p> <p><input type="checkbox"/> 2 - 10 minutes</p> <p><input type="checkbox"/> Less than 2 minutes</p>	<p>13) How do you climb up stairs? (Answer only if you are able to walk.)</p> <p><input type="checkbox"/> Normally <input type="checkbox"/> Need 1 rail</p> <p><input type="checkbox"/> Need 2 rails <input type="checkbox"/> Unable to climb stairs</p>
<p>14) How much do you limp when you don't use support?</p> <p><input type="checkbox"/> No limp <input type="checkbox"/> Slight limp</p> <p><input type="checkbox"/> Moderate limp <input type="checkbox"/> Severe limp</p>	<p>15) How difficult is it for you to put on your shoes and socks?</p> <p><input type="checkbox"/> No trouble</p> <p><input type="checkbox"/> Able, but with difficulty</p> <p><input type="checkbox"/> Extremely difficult</p> <p><input type="checkbox"/> Unable</p>
<p>16) How do you go down stairs?</p> <p><input type="checkbox"/> Normally, no rails</p> <p><input type="checkbox"/> Need 1 rail</p> <p><input type="checkbox"/> Hip or knee creates instability or balance issues</p>	<p>17) How does your hip or knee affect your ability to get in and out of a car?</p> <p><input type="checkbox"/> Do it with ease</p> <p><input type="checkbox"/> With difficulty</p> <p><input type="checkbox"/> Unable</p>
<p>18) How difficult is it for you to go from sitting to standing?</p> <p><input type="checkbox"/> Can stand up from chair without arms</p> <p><input type="checkbox"/> Must use arms to stand up from chair</p> <p><input type="checkbox"/> Unable to stand up</p>	<p>19) Does your hip or knee pain cause:</p> <p><input type="checkbox"/> Sense of grinding</p> <p><input type="checkbox"/> Instability or giving way</p> <p><input type="checkbox"/> Falls</p>
<p>20) Does your hip or knee interfere with your sleep cycle?</p> <p><input type="checkbox"/> Difficulty falling asleep</p> <p><input type="checkbox"/> Pain or discomfort awakens you from sleep</p> <p><input type="checkbox"/> No effect on sleep</p>	<p>21) Conditions other than current problem which impair ambulation (select all that apply).</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Foot/ankle</p> <p><input type="checkbox"/> Lungs</p> <p><input type="checkbox"/> Heart</p> <p><input type="checkbox"/> Neurologic (stroke, paralysis)</p> <p><input type="checkbox"/> Psychological</p> <p><input type="checkbox"/> Other</p>
<p>22) Activities you want to do but can't because of your hip or knee (select all that apply).</p> <p><input type="checkbox"/> No limits <input type="checkbox"/> Golf <input type="checkbox"/> Skiing</p> <p><input type="checkbox"/> Baseball <input type="checkbox"/> Hiking <input type="checkbox"/> Stairs</p> <p><input type="checkbox"/> Softball <input type="checkbox"/> Jogging <input type="checkbox"/> Stooping</p> <p><input type="checkbox"/> Basketball <input type="checkbox"/> Lawn mowing <input type="checkbox"/> Swimming</p> <p><input type="checkbox"/> Biking <input type="checkbox"/> Lifting <input type="checkbox"/> Tennis</p> <p><input type="checkbox"/> Carrying <input type="checkbox"/> Sex <input type="checkbox"/> Walking</p> <p><input type="checkbox"/> Gardening <input type="checkbox"/> Skating <input type="checkbox"/> Other</p>	