



## THE STEADMAN CLINIC

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181 W Meadow Drive  
STE 400  
Vail Colorado 81657  
T 970.476.1100  
F 970.479.5813  
[www.steadmanclinic.net](http://www.steadmanclinic.net)

Thank you for choosing The Steadman Clinic!

Please complete the attached forms in their entirety and you can bring the day of your appointment or if you prefer, you complete and return via email or fax.

Please come to your visit prepared with the following items:

- Completed Registration Paperwork
- Steadman Philippon Research Form
- Insurance Card(s) or proof of insurance
- Identification with a your picture
- All Medical Records pertaining to the body part for which you are being treated (MRI images, xrays, MRI Report, Operative Report, Clinic Notes etc.)

Thank you and please feel free to contact me directly with any questions you may have!

*Amanda Peña*

Practice Coordinator and Executive Assistant for Robert F. LaPrade, MD, PhD

**The Steadman Clinic**

181 West Meadow Drive , STE 400

Vail Colorado 81657

970.479.5881 DIRECT

970.476.1100 MAIN

970.479.5816 FAX

[WWW.STEADMANCLINIC.NET](http://WWW.STEADMANCLINIC.NET)



STEADMAN CLINIC  
Keeping People Active

# STEADMAN CLINIC REGISTRATION

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last First (Legal) Initial Nickname

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  Male  Female

Home phone \_\_\_\_\_ Work \_\_\_\_\_ Fax \_\_\_\_\_

Cell Phone \_\_\_\_\_ e-mail Address \_\_\_\_\_

Permanent Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Local Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Retired? Y N

Marital Status S M W D Spouse's Full Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Relative to contact in case of an emergency \_\_\_\_\_  
( A relative not living with you)

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

## Injury Information:

Date of injury \_\_\_\_\_ Work related: No  Yes  Auto Accident: No  Yes

What is injured \_\_\_\_\_

Describe injury \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Policy ID Number \_\_\_\_\_ Group \_\_\_\_\_  
Name of the Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security number \_\_\_\_\_ Sex M F  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Policy ID Number \_\_\_\_\_ Group \_\_\_\_\_  
Name of the Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M F  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**WORKMAN'S COMPENSATION INSURANCE:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Claim Number \_\_\_\_\_ Case Worker's Name \_\_\_\_\_  
Case Worker's Phone Number \_\_\_\_\_ Fax \_\_\_\_\_  
Employer at time of injury \_\_\_\_\_  
Address \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

*Steadman Clinic, Professional LLC*

**STATEMENT OF FINANCIAL LIABILITY**

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges at the time of the visit. I understand that unless otherwise indicated below, I hereby request and authorize Steadman Clinic to bill insurance policies written in the United States, and insurance companies based in the United States, for surgical and other charges for services provided to me, and I authorize payment to the Steadman Clinic for all such services. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility. I also understand that Steadman Clinic physicians are investors in the Vail Valley Surgery Center.

**NOTICE OF LIABILITY FOR “NON-COVERED” SERVICES**

I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by Steadman Clinic, such as assistant surgeons, and supplies, to be “non-covered,” and I am fully responsible for payment of all such non-covered services.

**WAIVER OF “USUAL, CUSTOMARY AND REASONABLE” CLAUSES**

For patients with “UCR” coverage I acknowledge that the fees charged by Steadman Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered “usual, customary and reasonable,” due to specialized services and staff. However, I agree to pay all fees in full, even if the amount is greater than the amount paid by my insurance company.

**CHANGES TO BILL TO/PAYMENT INSTRUCTIONS**

By checking the box to the left, I hereby direct that Steadman Clinic SHALL NOT bill my insurance company for services provided to me, and instead I agree to pay all fees for services furnished to me by Steadman Clinic.

**PERMISSION TO RELEASE MEDICAL INFORMATION**

I authorize Steadman Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to Steadman Clinic or its affiliates until written notice revoking it is provided. I release Steadman Clinic of all responsibility or liability for loss of confidentially through access and/or copies of records released, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions there in regarding responsibility for payments and release of information.

Patient’s Name: \_\_\_\_\_

Patient or Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Legal Guardian, Relationship to Patient: \_\_\_\_\_



# Acknowledgement of Notice of Privacy Practices

**STEADMAN CLINIC**  
*Keeping People Active*

.....  
Name of Patient *(please print)*

.....  
Date of Birth

**I hereby acknowledge that I received the Steadman Clinic’s Notice of Privacy Practices.**

.....  
Signature of patient or patient representative

.....  
Date

**Documentation of Good Faith Efforts**  
**To obtain patient’s acknowledgement that they received provider’s**  
**Notice of Privacy Practices**

*(For use when acknowledgement cannot be obtained from the patient.)*

The patient presented to the office/hospital on ..... and was provided with a copy of Covered Entity’s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign
- Patient was unable to sign or initial because: .....
- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- Other reason (describe below): .....

.....  
Signature of Employee Completing Form

.....  
Date

*[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider’s Notice of Privacy Practices, the provider should document the “Good Faith Efforts” taken to obtain such acknowledgement. The regulation does not specify how those “Good Faith Efforts” should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]*



# PATIENT HISTORY

Please PRINT and fill out completely.

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ What body part is injured: \_\_\_\_\_  Right  Left  
Hand Dominance:  Right  Left

## HISTORY OF INJURY

Is the injury **CHRONIC**?  Yes  No If **YES**, how long has it been going on for? \_\_\_\_\_

Is the injury **NEW** as a result of a specific injury?  Yes  No If **YES**, date of injury/accident: (full date) \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe in your own words how the initial injury occurred and how it limits your current level of activity:  
\_\_\_\_\_  
\_\_\_\_\_

Did your problems begin following:  Work injury?  Motor Vehicle Accident? **What State?** \_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (10 being the most painful): At rest: 0 1 2 3 4 5 6 7 8 9 10  
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Is the pain:  Worsening  Stable  Improving  Constant  Occasional  Sharp  Dull  
 Aching  Stabbing  Throbbing

What symptoms are you experiencing?  Locking  Catching  Giving Way  Popping  Grinding  Bruising  
 Numbness  Tingling  Other (describe) \_\_\_\_\_

What, if anything, makes your symptoms *better*?  Rest  Activity  Cold Therapy  Heat Therapy  
 Medication  Other \_\_\_\_\_

What, if anything, makes your symptoms *worse*?  Inactivity  Exercise (describe) \_\_\_\_\_  
 Other \_\_\_\_\_

Have you seen another physician for this injury?  Yes  No  
If yes, who? \_\_\_\_\_

What treatments have you tried?  Nothing  Physical Therapy  Exercise  Acupuncture  
 Chiropractic  Bracing  Injections (i.e: Synvisc, Hyalgan)  Ice  Decreased activity  
 Medications \_\_\_\_\_  Other \_\_\_\_\_

Have you had any of the following tests/studies?

Test	Date (month / year)	What facility? (clinic / hospital)
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Recreational Activities: \_\_\_\_\_

Current, regular exercise program (if any): \_\_\_\_\_

**PAST MEDICAL HISTORY**

Check if you currently suffer or have previously suffered from:

- |   |       |              |       |   |       |              |       |
|---|-------|--------------|-------|---|-------|--------------|-------|
| <input type="checkbox"/> High blood pressure      | _____ | <i>When?</i> | _____ | <input type="checkbox"/> Osteoporosis   | _____ | <i>When?</i> | _____ |
| <input type="checkbox"/> Deep vein thrombosis     | _____ |              |       | <input type="checkbox"/> Kidney Disease/Problem   | _____ |              |       |
| <input type="checkbox"/> Liver Disease            | _____ |              |       | <input type="checkbox"/> Seizures   | _____ |              |       |
| <input type="checkbox"/> Heart Disease or Attack  | _____ |              |       | <input type="checkbox"/> Arthritis  | _____ |              |       |
| <input type="checkbox"/> Stroke                   | _____ |              |       | <input type="checkbox"/> Thyroid <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo | _____ |              |       |
| <input type="checkbox"/> Cancer ( <i>where?</i> ) | _____ |              |       | <input type="checkbox"/> Tuberculosis   | _____ |              |       |
| <input type="checkbox"/> Elevated cholesterol     | _____ |              |       | <input type="checkbox"/> Pulmonary embolism   | _____ |              |       |
| <input type="checkbox"/> Ulcer Disease            | _____ |              |       | <input type="checkbox"/> Polio  | _____ |              |       |
| <input type="checkbox"/> Gastritis                | _____ |              |       | <input type="checkbox"/> Rheumatic Fever  | _____ |              |       |
| <input type="checkbox"/> Reflux Disease (GERD)    | _____ |              |       | <input type="checkbox"/> Gout   | _____ |              |       |
| <input type="checkbox"/> Asthma                   | _____ |              |       | <input type="checkbox"/> Depression   | _____ |              |       |
|   |       |              |       | <input type="checkbox"/> Diabetes   | _____ |              |       |

Others, please list: \_\_\_\_\_  
Have you ever had a blood transfusion? Yes No If yes, when? \_\_\_\_\_

**GASTROINTESTINAL HISTORY**

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? \_\_\_\_\_  
Do you have a history of GI, stomach bleed? Yes No If yes, when? \_\_\_\_\_

Do you take any medications for your stomach? (*Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc., dosage and frequency.*) \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list all surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with Anesthesia? Yes No Please explain if **YES**: \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medication? Yes No **known drug allergies**  
If **YES**, please list all medications that you are allergic to and the associated reaction (i.e. Penicillin (hives) etc): \_\_\_\_\_

**Are you allergic to:** Sulfa? Yes No Latex? Yes No Steroids? Yes No  
Please list all food allergies (i.e. eggs, shellfish): \_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY**

Marital Status:  Married  Single  Divorced  Widowed  Living with other  Living alone

Occupation: \_\_\_\_\_

Tobacco Use:  Yes  No Type: \_\_\_\_\_ Duration: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Alcohol Use:  Yes  No Frequency: \_\_\_\_\_

Caffeine Use:  Yes  No Frequency: \_\_\_\_\_

Recreational Drug Use:  Yes  No Frequency: \_\_\_\_\_

**FAMILY HISTORY**

Please check family history conditions:

Blood Clots  Diabetes  Hypertension  Rheumatoid Arthritis  Anesthetic problems  
 Cancer  Heart Disease  Osteoporosis  Stroke  Seizures

Please describe any immediate family history medical problems: \_\_\_\_\_

**REVIEW OF SYSTEMS**

1. CONSTITUTIONAL GENERAL  None  Weight gain  Weight loss  Chills  Fever  Weakness/Fatigue  
 Other \_\_\_\_\_

2. EYES  None  Blurred vision  Glasses  Contacts  Eye pain  Redness  
 Other \_\_\_\_\_

3. EARS, NOSE, THROAT  None  Nose bleeds  Ear ache or infection  Ringing in ear  Hoarseness  
 Other \_\_\_\_\_

4. CARDIOVASCULAR  None  Chest Pain  Swelling in legs  Shortness in breath  Palpitations  
 Other \_\_\_\_\_

5. RESPIRATORY  None  Shortness of breath  Wheezing/Asthma  Frequent Cough  
 Other \_\_\_\_\_

6. GASTROINTESTINAL  None  Heartburn  Vomiting  Nausea  Abdominal Pain  
 Other \_\_\_\_\_

7. MUSCULOSKELETAL  None  Stiffness  Muscle aches  Swelling of joints  Instability  
 Other \_\_\_\_\_

8. SKIN  None  Rash  Itching  Redness  Keloid scars  Psoriasis  
 Other \_\_\_\_\_

9. NEUROLOGICAL  None  Headaches  Numbness, tingling, loss of sensation in any part of body  
 Dizziness  Poor balance  Fainting spells  Seizures  
 Other \_\_\_\_\_

10. PSYCHIATRIC  None  Depression  Nervousness  Anxiety  
 Other \_\_\_\_\_

11. ENDOCRINE  None  Excessive thirst or hunger  Hot/cold intolerance  Hot Flashes  
 Other \_\_\_\_\_

12. HEMATOLOGICAL  None  Easy Bruising  Easy Bleeding  Varicose veins  Blood clots  
 Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

## LODGING ACCOMODATIONS

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### Vail Cascade Resort & Spa

1300 Westhaven Drive Vail, CO 81657  
(970) 476-7111  
Toll Free 1-800-420-2424  
[www.vailcascade.com](http://www.vailcascade.com)



### Evergreen Lodge

250 South Frontage Rd Vail CO 81657  
(970) 476-7810  
Toll Free 1-800-284-8245  
[www.evergreenvail.com](http://www.evergreenvail.com)



### The Lodge at Vail

174 E Gore Creek, Dr Vail, CO 81657  
(970) 476-5011  
Toll Free 1-800-331-5634  
[www.rockresorts.com](http://www.rockresorts.com)



### Sonnenalp Resort

20 Vail Rd Vail, CO 81657  
(970) 476-5656  
Toll Free 1-800-654-8312  
[www.sonnenalp.com](http://www.sonnenalp.com)



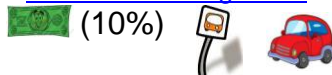
### Vail Plaza

16 Vail Road Vail, CO 81657  
(970) 477-8000  
Toll Free 1-866-597-5963  
[www.vailplazahotel.com](http://www.vailplazahotel.com)



### Sizmark Lodge- Andrea

183 E Gore Creek Dr Ste 1  
Vail, CO 81657  
(970) 476-5001  
Toll Free 1-888-476-5001  
[www.sizmarklodge.com](http://www.sizmarklodge.com)




### Holiday Inn

2211 N. Frontage Rd. (West Vail)  
(970)476-2739  
Toll Free 1-866-317-2739  
[www.holidayinn.com](http://www.holidayinn.com)



### CONDOS:

**Vail Realty-** Discounted condos and rental properties in Vail & Beaver Creek  
(970)476-8800

Toll Free 1-800-627-VAIL (8245)  
[www.vailrealty.com](http://www.vailrealty.com)  (50%) 

### Vail Run

1000 Lions Ridge Loop, Vail, CO 81657  
(970) 476-1500  
[www.vailrunresort.com](http://www.vailrunresort.com)



### Vail International

300 E Lionshead Circle  
Vail, CO 81657  
(970) 476-0111  
Toll Free 1-800-622-3477  
[www.vailinternational.com](http://www.vailinternational.com)




### Simba Run Resort

1100 N Frontage Rd W.  
Vail, CO 81657  
(970) 476-0344  
Toll Free 1-800-746-2278  
[www.simbarun.com](http://www.simbarun.com)



### The Willows – Don Hancock

774 Willow Rd Vail, CO 81657  
(970) 476-2233  
Toll Free 1-888-945-5697  
[www.willowscondos.com](http://www.willowscondos.com)  
 (10%)



### Hospital Shuttle Service



**Steadman/HHSM Discount (rates depend on season/availability)**



**Located on Town Bus Route**

**NOTE: Please be aware that buses can be difficult to get into after surgery.**

## Accommodations/Transportation

In preparing for your stay in Vail, the following are phone numbers for some local hotels and condominiums in the Vail/Beaver Creek area that offer discounts to our patients.

Comfort Inn (Avon, CO)	800-545-8422	970-949-5511	<a href="http://www.comfortinn.com">www.comfortinn.com</a>
Evergreen Lodge at Vail	800-284-8245	970-476-7810	<a href="http://www.evergreenvail.com">www.evergreenvail.com</a>
Holiday Inn Apex Vail	866-317-2739	970-476-2739	<a href="http://www.apexvail.com">www.apexvail.com</a>
Lion Square Lodge	800-525-1943	970-476-2281	<a href="http://www.lionsquare.com">www.lionsquare.com</a>
Mountain Haus	800-237-0922	970-476-2434	<a href="http://www.mountainhaus.com">www.mountainhaus.com</a>
Simba Run Condominiums	800-746-2278	970-476-0344	<a href="http://www.simbarun.com">www.simbarun.com</a>
Sonnenalp Resort of Vail	866-284-4411	970-476-5656	<a href="http://www.sonnenalp.com">www.sonnenalp.com</a>
The Sitzmark Lodge	888-476-5001	970-476-5001	<a href="http://www.sitzmarklodge.com">www.sitzmarklodge.com</a>
The Lodge at Vail	877-528-7625	970-476-5011	<a href="http://www.lodgeatvail.com">www.lodgeatvail.com</a>
Vail Cascade Resort	800-282-4183	970-476-7111	<a href="http://www.vailcascade.com">www.vailcascade.com</a>
Vail Plaza Hotel	866-597-5963	970-477-8000	<a href="http://www.vailplazahotel.com">www.vailplazahotel.com</a>

### **Airport Shuttle Services:**

Colorado Mountain Express (CME)	800-525-6363	970-926-9800	<a href="http://www.ridecme.com">www.ridecme.com</a>
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### **Rental Cars:**

Alamo- Eagle Airport	800-462-5266	970-524-2277	<a href="http://www.alamo.com">www.alamo.com</a>
Avis – Eagle Airport	800-331-1212	970-524-7571	<a href="http://www.avis.com">www.avis.com</a>
Budget – Eagle Airport	800-527-0700	970-524-8260	<a href="http://www.budget.com">www.budget.com</a>
Dollar- Eagle Airport	800-800-4000	970-524-9429	<a href="http://www.dollar.com">www.dollar.com</a>
Hertz- Eagle Airport	800-654-3131	970-524-7177	<a href="http://www.hertz.com">www.hertz.com</a>
National – Eagle Airport	800-227-7368	970-524-2277	<a href="http://www.nationalcar.com">www.nationalcar.com</a>

### **Taxis, Limousines:**

Black Diamond	970-261-6509		<a href="http://www.blackdiamondcars.com">www.blackdiamondcars.com</a>
Eco Limo of Vail	970-331-3135		<a href="http://www.ecolimoofvail.com">www.ecolimoofvail.com</a>
Hummers of Vail	970-977-0028		<a href="http://www.hummersofvail.com">www.hummersofvail.com</a>
Powderhound Transport	970-455-4315		<a href="http://www.ridethepowder.com">www.ridethepowder.com</a>
RJ Limo of Vail	800-887-9643		<a href="http://www.limovail.com">www.limovail.com</a>
Vail Coach	877-554-7433	970-477-0001	<a href="http://www.vailcoach.com">www.vailcoach.com</a>
Vail Local Limo	970-343-0500		<a href="http://www.vaillocallimo.com">www.vaillocallimo.com</a>
Vail Valley Taxi	970-476-8294		

### **Buses:**

Town of Vail Bus Schedules	970-479-2178		<a href="http://www.vailgov.com">www.vailgov.com</a>
Eagle County Bus Schedules	970-328-3520		<a href="http://www.eaglecounty.us">www.eaglecounty.us</a>



*Care and Concierge Services*

***Here 2 Help of Vail*** is a business providing valuable services to our patients:

- ***Trip Planning-*** *They can assist you with all aspects of the planning of your trip. (Complimentary service)*
  - *They will advise you on the best hotel/accommodations and ground transportation for your specific needs.*
  - *They can assist you with general logistics*
  - *Informative web site*
  
- ***Care Services -*** *They can provide you with pre and post operative non medical care. (Fee services)*
  - *Assist with your Release/Discharge from the hospital*
  - *Become your Responsible Party*
  - *Rehab Machine Set Up and Instructions*
  - *Self Care Education*
  - *At Home Care*
  - *Night Time Care (advance notice required)*
  
- ***Concierge Services –*** *Whatever it takes to help **Making Your Life Easier!** (Fee Services)*
  - *Arrange local transportation*
  - *Arrange activities for family or friends*
  - *Grocery shopping - Errands*
  - *Dog walking*
  - *Meals – cook in, bring in or dine out*
  - *Household tasks*

***Here 2 Help's experienced staff is ready to help you!***

**Go to [www.here2helpvail.com](http://www.here2helpvail.com) or call 970-949-4248**

***Making Your Life Easier!***

## Directions

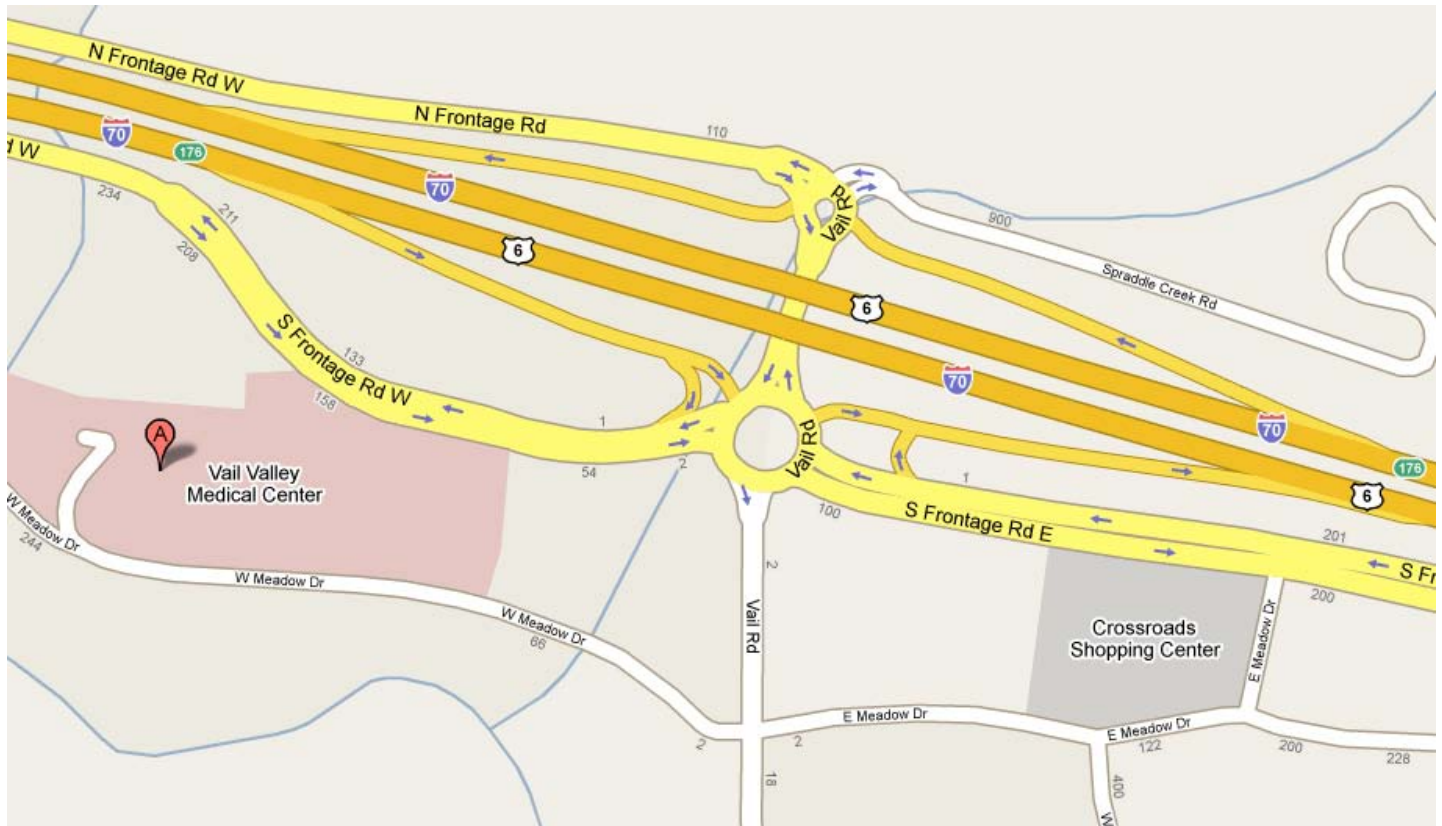
The Steadman Clinic  
181 West Meadow Drive, Suite 400  
Vail, Colorado 81657  
970-476-1100

### **FROM DENVER (EAST) TO VAIL (WEST)**

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading west. Go approximately one hundred and twenty miles (120) to Vail, Exit 176. Follow the roundabout half way around and exit in the direction of Vail Village. Enter the second roundabout and exit in the direction of Vail Road. Go to the stop sign and turn right onto West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman Clinic is located on the third floor of the hospital.

### **FROM EAGLE (WEST) TO VAIL (EAST)**

Exit Eagle County Airport and turn left (east) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Exit the roundabout in the direction of Vail road. Go to the stop sign and turn right on West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman Clinic is located on the third floor of the hospital.



# Steadman Philippon Research Institute

## New Patient or New Injury - Knee Form

NAME: \_\_\_\_\_ MED. REC #

DATE:  /  /

Height  ft  in Weight   lbs

**INJURED KNEE:**  
 Right  
 Left  
 Both Knees

**DOCTOR:**  
 Dr. Steadman  
 Dr. Sterett  
 Dr. Millett  
 Dr. LaPrade

### Injury and Previous Surgery Information

**1. Most recent injury date OR date of onset of symptoms:**  /  /

**How did your injury happen (check as many as apply)?**

- |  |  |  |
|--|--|--|
| <input type="radio"/> No specific injury | <input type="radio"/> Blow to the Knee | <input type="radio"/> Participating in a Sport     |
| <input type="radio"/> Auto Accident      | <input type="radio"/> Twisted Knee     | What sport? _____                                  |
| <input type="radio"/> Slip and/or Fall   | <input type="radio"/> Jumping Activity | <input type="radio"/> Other, PLEASE specify: _____ |
| <input type="radio"/> Lifting Activity   |  |  |

1	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>
0	<input type="radio"/>	<input type="radio"/>

**2. What is your reason(s) for seeking medical attention?**  
 Pain    Unstable knee    Loss of function    Weakness    Stiffness    Other

**3. Is there a workers' compensation claim involved with your injury?**    Yes    No

**4. If you have had any knee injuries PRIOR to your most recent injury, please list below:**

A) Date:  /  /     Which Knee:  Right    Left    Both Knees

B) Date:  /  /     Which Knee:  Right    Left    Both Knees

**5. Have you had previous knee surgery?**    Yes    No   If yes, how many?    **RIGHT KNEE SURGERIES**    **LEFT KNEE SURGERIES**

**Please list most recent below:**

A) Date:  /  /     Which Knee:  Right    Left   Procedure:  Ligament    Meniscus    Cartilage  
 Arthroscopy/Debridement    Other

B) Date:  /  /     Which Knee:  Right    Left   Procedure:  Ligament    Meniscus    Cartilage  
 Arthroscopy/Debridement    Other

C) Date:  /  /     Which Knee:  Right    Left   Procedure:  Ligament    Meniscus    Cartilage  
 Arthroscopy/Debridement    Other

### Sport Participation Information (if applicable)

**6. Primary Sport:** \_\_\_\_\_ **Number of Years Played:** \_\_\_\_\_

- 7. What level of sports did you recently participate in prior to injury?**
- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| <input type="radio"/> Recreational Part-time (1-3 per week) | <input type="radio"/> High School | <input type="radio"/> Pro-Minors |
| <input type="radio"/> Recreational Full-time (4-7 per week) | <input type="radio"/> College     | <input type="radio"/> Pro-Majors |
- 8. What activity level would you like to get back to?**
- |  |  |  |
|--|--|--|
| <input type="radio"/> Sedentary            | <input type="radio"/> Scholastic Competitive Athlete | <input type="radio"/> Professional Athlete |
| <input type="radio"/> Recreational Athlete | <input type="radio"/> Competitive Athlete            |  |

	SPRT		YR	
1	<input type="radio"/>	<input type="radio"/>	1	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>	2	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	3	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>	4	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>	5	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>	6	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>	7	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>	8	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>	9	<input type="radio"/>
0	<input type="radio"/>	<input type="radio"/>	0	<input type="radio"/>

**9. Following your injury, are you currently:**

<input type="radio"/> Not Limited in Sports	<input type="radio"/> Unable to Participate in a MAJORITY of Sports
<input type="radio"/> Unable to Participate in a FEW Sports	<input type="radio"/> Unable to Participate in ALL Sports

10. Please grade each symptom that you experience currently during your highest level of activity.

Please fill out both knees

	LEFT KNEE				RIGHT KNEE			
	NONE	MILD	MODERATE	SEVERE	NONE	MILD	MODERATE	SEVERE
a) Pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
b) Full Giving Way	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
c) Noise Sensations	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
d) Joint Stiffness	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

11. During the past 4 weeks or since your injury, how often have you had pain?

NEVER  0  1  2  3  4  5  6  7  8  9  10 CONSTANT

12. If you have pain, how severe is it?

NO PAIN  0  1  2  3  4  5  6  7  8  9  10 WORST PAIN IMAGINABLE

13. Please grade each symptom that you experience currently during your highest level of activity

**Swelling:**  None  Mild (on severe exertion)  Moderate (on ordinary exertion)  Severe (constant)

**Pain:**  None  Marked on or after walking more than 2 km  
 Inconstant and slight during severe exertion  Marked on or after walking less than 2 km  
 Marked during severe exertion  Constant

**Crutch Use:**  None  1 Crutch (stick or crutch)  2 Crutch (stick or crutch)  Weight bearing impossible

**Walk with Limp:**  No (none)  Somewhat (slight or periodical)  Yes (severe or constant)

**Locking:**  No locking and no catching sensations  Locking frequently  Locking occasionally  
 Catching sensations but no locking  Locked joint

**Instability:**  Never giving way  Occasionally in daily activities  
 Rarely during athletics or other severe exertion  Often in daily activities  
 Frequently during athletics or other severe exertion  Every step

**Stair Climbing:**  No problems  Slightly impaired  One step at a time  Impossible

**Squatting:**  No problems  Slightly impaired  Not beyond 90 degrees  Impossible

14. During the past 4 weeks or since your injury did your knee lock or catch?  No  Yes

15. During the past 4 weeks or since your injury how stiff or swollen was your knee?

Not at all  Mildly  Moderately  Very  Extremely

16. Answer the next 2 questions using the following definition:

**Very Strenuous**=activities like jumping/pivoting like in basketball or soccer. **Strenuous** = activities like heavy physical work, skiing, or tennis. **Moderate** = activities like moderate physical work, running or jogging. **Light** =activities like walking, housework, or yard work

What is the highest level of activity you can perform without significant:

Knee pain  Very Strenuous  Strenuous  Moderate  Light  Unable  
 Giving way in your knee  Very Strenuous  Strenuous  Moderate  Light  Unable  
 Swelling in your knee  Very Strenuous  Strenuous  Moderate  Light  Unable

What is the highest level of activity you can participate in on a regular basis?

Very Strenuous  Strenuous  Moderate  Light  Unable

17. How does your knee affect your activity level?

No Affect  Mildly  Moderately  Severely

18. Currently, how does your knee function:

Normal  Nearly Normal  Abnormal  Severely Abnormal



How important are these expectations in the treatment of your knee?		Very Important	Somewhat Important	A little Important	I do not expect this	Does not Apply
If you expect pain relief, mark one:	<b>Relieve pain</b> <input type="radio"/> Relieve some pain <input type="radio"/> Relieve most pain <input type="radio"/> Relieve all pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to walk</b> <input type="radio"/> Short distance (indoors, 1 block) <input type="radio"/> Medium distance (less than 1 mile) <input type="radio"/> Long distance (more than 1 mile)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Increase knee stability</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Increase knee mobility</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to go up and down stairs</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to squat</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to kneel</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Stop knee from catching or buckling</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Stop knee from giving way when coming to a quick stop while running</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Stop knee stiffness or swelling</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Be employed for monetary reimbursement</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to run (for example across the street, to catch a bus)</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to perform daily activities (for example daily routine, household chores)</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
If you expect this, mark on one:	<b>Improve ability to exercise or participate in sports</b> <input type="radio"/> Participate in recreational sports <input type="radio"/> Participate in professional sports	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Have confidence in knee</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Avoid future degeneration of knee</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to maintain general health</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve ability to interact with others (for example take care of someone, play with children)</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>Improve psychological well being</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b>For knee to be back to the way it was before this problem started</b>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

How would you rate the function of your knee on a scale of 0 to 10.

	Normal Excellent function										Cannot perform daily activities
CURRENT FUNCTION OF YOUR KNEE	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 0
FUNCTION PRIOR TO INJURY	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 0

Rate your current ability to perform

	NO LIMITATION										UNABLE TO PERFORM
Activities of Daily Living	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	
Strenuous work (vigorous activities)	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	
Sports	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	
Sedentary Work (sitting activities)	<input type="radio"/> 10	<input type="radio"/> 9	<input type="radio"/> 8	<input type="radio"/> 7	<input type="radio"/> 6	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	



**Please answer the following questions for your injured knee. Grade each symptom to indicate the degree of severity. All questions are about how you have felt on average during the past month.**

Pain - Walking                     NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Pain - Stair climbing             NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Pain - Nocturnal                  NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Pain - Rest                         NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Pain - Weightbearing             NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Morning Stiffness                NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Stiffness occurring  
later in the day                  NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

**Please grade the level of difficulty you have performing the following functions:**

Descending stairs                NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Ascending stairs                 NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Rising from sitting               NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Standing                          NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Bending to floor                 NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Walking on flat                  NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Getting in/out car                NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Going shopping                  NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Putting on socks                 NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Rising from beds                 NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Taking off socks                 NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Lying in bed                     NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Getting in/out bath              NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Sitting                           NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Getting on/off toilet             NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Heavy domestic duties          NONE    SLIGHT    MODERATE    SEVERE    EXTREME

---

Light domestic duties          NONE    SLIGHT    MODERATE    SEVERE    EXTREME



**INSTRUCTIONS:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

Shade circles like this: ●

1) In general, would you say your health is:							
<input type="radio"/> Excellent <input type="radio"/> Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor							
The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?					Yes, limited	Yes, limited a little	No, not limited at all
2) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Climbing several flights of stairs					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During the past <u>4 weeks</u> , have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u> ?					Yes	No	
4) Accomplished less than you would like					<input type="radio"/>	<input type="radio"/>	
5) Were limited in the kind of work or other activities					<input type="radio"/>	<input type="radio"/>	
During the past week, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?					<b>Yes</b>	<b>No</b>	
6) Accomplished less than you would like					<input type="radio"/>	<input type="radio"/>	
7) Didn't do work or other activities as carefully as usual					<input type="radio"/>	<input type="radio"/>	
8) During the <u>past 4 weeks</u> , how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?					<input type="radio"/> Not at all	<input type="radio"/> Quite a bit	
					<input type="radio"/> A little bit	<input type="radio"/> Extremely	
					<input type="radio"/> Moderately		
These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u> . For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past Weeks</u> -							
	All of the Time	Most of the Time	A good Bit of the Time	Some of the Time	A Little of the Time	None of the Time	
9) Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
10) Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
11) Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
12) During the <u>past 4 weeks</u> , how much of the time has <u>your physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?							
<input type="radio"/> All of the time <input type="radio"/> Some of the time <input type="radio"/> None of the time <input type="radio"/> Most of the time <input type="radio"/> A little of the time							







THE STEADMAN CLINIC  
*Keeping People Active*

Name: \_\_\_\_\_  
Last First MI

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

## KNEE EVALUATION

Have you ever had an MRI in Vail, CO? YES \_\_\_\_\_ NO \_\_\_\_\_

1. What was your chief complaint when you visited your doctor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. What do you think caused the problem? \_\_\_\_\_  
\_\_\_\_\_
3. What does the doctor think is causing your problem? If there was an injury please give the date. \_\_\_\_\_  
\_\_\_\_\_
4. Describe your pain/symptoms \_\_\_\_\_  
\_\_\_\_\_
  - a. What makes the pain better? \_\_\_\_\_
  - b. What makes the pain worse? \_\_\_\_\_
5. Do you have any weakness? \_\_\_\_\_ Where? \_\_\_\_\_
6. Have you had knee surgery? \_\_\_\_\_  
When? \_\_\_\_\_  
What was done? \_\_\_\_\_  
Left \_\_\_\_\_ Right \_\_\_\_\_
7. Do you have any arthritis in any other joints? \_\_\_\_\_ Where? \_\_\_\_\_
8. Do you currently take any medications? \_\_\_\_\_ What? \_\_\_\_\_  
\_\_\_\_\_
9. Do you have any other medical conditions? \_\_\_\_\_  
\_\_\_\_\_
10. List any athletic activities that may have contributed to your condition: \_\_\_\_\_  
\_\_\_\_\_