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1. Do you smoke cigarettes?

- Yes
- No, I quit in the last six months.
- No, I quit more than six months ago.
- No, I have never smoked.

2. Your height _____ centimeters inches

3. Your weight _____ kilograms pounds

4. Your race (indicate all that apply)

- White Black or African-American Hispanic
- Asian or Pacific Islander Native American Indian Other

5. How much school have you completed?

- Less than high school Graduated from high school Some college
- Graduated from college Postgraduate school or degree

6. Activity level

- Are you a high competitive sports person?
- Are you well-trained and frequently sporting?
- Sporting sometimes
- Non-sporting

IKDC CURRENT HEALTH ASSESSMENT FORM *

Your Full Name _____

Your Date of Birth _____ / _____ / _____
Day Month Year

Today's Date _____ / _____ / _____
Day Month Year

1. In general, would you say your health is: Excellent Very Good Good Fair Poor
2. Compared to one year ago, how would you rate your health in general now?
Much better now than 1 year ago Somewhat better now than 1 year ago About the same as 1 year ago
Somewhat worse now than 1 year ago Much worse now than 1 year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking more than a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks, 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)?

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

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6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not At All Slightly Moderately Quite a Bit Extremely

7. How much bodily pain have you had during the past 4 weeks?

- None Very Mild Mild Moderate Severe Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at All A Little Bit Moderately Quite a Bit Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. 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 past 4 weeks...

	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
a. Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you felt down-hearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you been a happy person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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2000 IKDC SUBJECTIVE KNEE EVALUATION FORM

Your Full Name _____

Today's Date: ____/____/____
Day Month Year

Date of Injury: ____/____/____
Day Month Year

SYMPTOMS*:

*Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activities at this level.

1. What is the highest level of activity that you can perform without significant knee pain?

- 4 Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 Strenuous activities like heavy physical work, skiing or tennis
- 2 Moderate activities like moderate physical work, running or jogging
- 1 Light activities like walking, housework or yard work
- 0 Unable to perform any of the above activities due to knee pain

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

10 9 8 7 6 5 4 3 2 1 0
Never Constant

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

10 9 8 7 6 5 4 3 2 1 0
No pain Worst pain imaginable

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

- 4 Not at all
- 3 Mildly
- 2 Moderately
- 1 Very
- 0 Extremely

5. What is the highest level of activity you can perform without significant swelling in your knee?

- 4 Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 Strenuous activities like heavy physical work, skiing or tennis
- 2 Moderate activities like moderate physical work, running or jogging
- 1 Light activities like walking, housework, or yard work
- 0 Unable to perform any of the above activities due to knee swelling

6. During the past 4 weeks, or since your injury, did your knee lock or catch?

- 0 Yes
- 1 No

7. What is the highest level of activity you can perform without significant giving way in your knee?

- 4 Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 Strenuous activities like heavy physical work, skiing or tennis
- 2 Moderate activities like moderate physical work, running or jogging
- 1 Light activities like walking, housework or yard work
- 0 Unable to perform any of the above activities due to giving way of the knee

PATIENT DEMOGRAPHIC INSURANCE FORM

Name: _____ Today's Date: _____

Address: _____ Apt # _____ City / Town _____

State _____ Zip code _____ * E-MAIL _____

Telephone: _____ Work #: _____ Cell #: _____

Date of Birth: _____ Sex: Male ___ Female ___ Social Security # _____ - _____ - _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___

Employer: _____

Primary Insurance Carrier: _____

Identification Number: _____

Name of Insured/Relation: _____ SS# _____ DOB _____

Secondary Insurance Carrier: _____ Identification Number: _____

Name of Insured/Relation: _____ SS# _____ DOB _____

Insured Employer: _____ Work Number: _____

Referral Source: MD: ___ Relative/Friend: ___ Yellow Pages: ___ Other: _____

Referring Physician _____ Office # _____

Physician Address: _____

Pharmacy: _____ Pharmacy Telephone #: _____

Pharmacy Address: _____

In care of emergency notify: _____ Telephone: _____

Relationship: _____

PLEASE DATE AND SIGN BELOW

The provider may release to governmental agencies, insurance carriers or their designated agents or the legal or financial departments representing me or the provider, all information needed to substantiate payment for my medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date: _____ Signed _____

I hereby assign, transfer, and set over to the above mentioned physician monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs of the treatment rendered to myself or my dependent, during this hospitalization.

Date: _____ Signed _____