RATE YOUR KNEE PAIN

Please complete the checklist below and print it out to discuss with your healthcare professional.

1. I usually experience knee pain:

☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Always

2. During the last week, how much pain did I experience during the following activities?

	None	Mild	Moderate	Severe	Extreme
a. Twisting/pivoting on your knee	☐	☐	☐	☐	☐
b. Straightening knee fully	☐	☐	☐	☐	☐
c. Bending knee fully	☐	☐	☐	☐	☐
d. Going up or down stairs	☐	☐	☐	☐	☐
e. At night while in bed	☐	☐	☐	☐	☐
f. Sitting or lying down	☐	☐	☐	☐	☐
g. Walking on even surfaces	☐	☐	☐	☐	☐
h. Standing upright	☐	☐	☐	☐	☐

3. I have already tried some treatments to help with my knee pain. ☐ Yes ☐ No

I'd like to discuss these points with my doctor:

_____

_____

KNEE PAIN RELIEF.CA kneepainrelief.ca

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