Visco Supplementation Intake Form

Patient Name: _____ DOB: _____

Please circle or complete the sentence.

1. Which knee is affected: ☐ Right ☐ Left
2. Does your knee make you less active than you would like to be? ☐ Yes ☐ No
3. What activities are affected by your knee pain?

   ☐ Walking ☐ Stairs ☐ Shopping ☐ Driving ☐ Yard Work ☐ Housework

   Other _____
4. Which of the following treatments have you had, and approximately when, with what results?

   ☐ *NO RELIEF* ☐ *SOME RELIEF* ☐ *GOOD RELIEF*

TREATMENT	***DATE***	***RESULT***
Tylenol		
NSAIDS		
☐ Advil ☐ Aleve ☐ Motrin ☐ Ibuprofen ☐ Celebrex ☐ Other _____		
Cortisone Injections		
Exercise		
☐ Gym Membership ☐ Stretching Walking ☐ Other _____		
Physical Therapy		
Walking Aid		
☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other _____		

Patient Signature: _____

Provider Signature: _____ Date: _____