



Acupuncture-Chiropractic-Massage Network - Pain Management Center, Inc.
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KNEE RE-EXAM as of ____ Chiropractic ____ Acupuncture ____ Massage **VISITS**

PATIENT:
Claim #:
Chart #:

Re-Exam Date (Now):
Initial Exam Date (Prior):
PTP:

INJURED SIDE: ☐ **RIGHT** ☐ **LEFT**

KNEE	PRIOR	CURRENT
Location		
% of Time	☐ 25% ☐ 50% ☐ 75% ☐ 90-100%	☐ 25% ☐ 50% ☐ 75% ☐ 90-100%
Numerical Scale	/10	/10
Functional Scale*	/80	/80 (80/80 = Full Function)
Medication		
Medication	☐ n/a: none	
Orthoses	☐ n/a: none	
+ Ortho/Neuro		
+ Ortho/Neuro		
Mood Complaint	☐ n/a: none	

*Functional Scale Attached

ROM – PRIOR & CURRENT

KNEE	R/L/Norm PRIOR	Pain PRIOR	R/L/Norm NOW	Pain NOW
Flexion	/150°	☐ R ☐ L	/150°	☐ R ☐ L
Extension	/0°	☐ R ☐ L	/0°	☐ R ☐ L

- ☐ **Improvement from the current course of care was demonstrated by the following**
- ☐ Decreased area of pain ☐ Decreased radiation of pain ☐ Decreased frequency of pain
 - ☐ Improved ability to perform ADL ☐ Decreased numerical rating of pain
 - ☐ Decreased use of medication ☐ n/a: not used when first seen or now
 - ☐ Decreased use of orthoses ☐ n/a: not used when first seen or now
 - ☐ Decreased positive ortho/neuro tests
 - ☐ Increased ROM ☐ Decreased ROM pain
 - ☐ Successful participation in a progressive conditioning program/decreased passive coping
 - ☐ Improved Mood ☐ n/a: no complaints when first seen or now

Patient:
Re-Exam Last Visit of Course:

2

- ☐ **Further improvement is anticipated from a new course of care REQUESTED to include**
Manual ☐ Manipulation ☐ Myofascial Release ☐ Mobilization ☐ Massage ☐ Massage 4 units
Exercise ☐ Strengthening ☐ Flexibility ☐ Cardio ☐ Proprioception ☐ Body Mechanics
Modalities ☐ Electrical: _____ ☐ Thermal: _____
☐ Instrument Assisted Soft Tissue Therapy
☐ Acupuncture/Electroacupuncture
☐ Pain Education ☐ Lifestyle Advice ☐ Other: _____
- ☐ **No improvement from current course of care and not anticipated from additional course**
- ☐ **Maximum Medical Benefit has been achieved from the current course of care**
- ☐ **Patient reports full recovery after completion of the current course of care**

Provider Name

Provider Signature

Lower Extremity Functional Scale

Please indicate whether you are having any difficulty with activities because of your lower limb problems by marking **one** answer for each activity listed below.

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities	☐	☐	☐	☐	☐
Your usual hobbies, recreational or sporting activities	☐	☐	☐	☐	☐
Getting into or out of the bath	☐	☐	☐	☐	☐
Walking between rooms	☐	☐	☐	☐	☐
Putting on your shoes or socks	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Lifting an object, like a bag of groceries from the floor	☐	☐	☐	☐	☐
Performing light activities around your Home	☐	☐	☐	☐	☐
Performing heavy activities around your Home	☐	☐	☐	☐	☐
Getting into or out of a car	☐	☐	☐	☐	☐
Walking 2 blocks	☐	☐	☐	☐	☐
Walking a mile	☐	☐	☐	☐	☐
Going up or down 10 stairs (about 1 flight of stairs)	☐	☐	☐	☐	☐
Standing for 1 hour	☐	☐	☐	☐	☐
Sitting for 1 hour	☐	☐	☐	☐	☐
Running on even ground	☐	☐	☐	☐	☐
Running on uneven ground	☐	☐	☐	☐	☐
Making sharp turns running fast	☐	☐	☐	☐	☐
Hopping	☐	☐	☐	☐	☐
Rolling over in bed	☐	☐	☐	☐	☐
		X 1 =	X 2 =	X 3 =	X 4 =

SCORE = ____/80