Self-Annotation by (last name): _____ DOB: _____ SSN: _____

KNEE ASSESSURE *of* PHYSICAL (KAP)© THERAPEUTICS

Patient full name: _____

This is a standardized form used to track conditions over the course of two (2) consecutive days following only the second (2nd) and eighth (8th) physical therapy sessions. Mail completed form to your PCP, Orthopedic Specialist, or Medical Records Department.

Physical Therapy location: _____ Session No: _____ Time: _____

Day 1

Date: _____, 2023

KNEE (Left)			
Time, Location, Activity, Treatment			
Pain	Buckling	Burning	Crackling

KNEE (Right)			
Time, Location, Activity, Treatment			
Pain	Buckling	Burning	Crackling

Self-Annotation by (last name): _____ DOB: _____ SSN: _____

Day 2

Date: _____, 2023

KNEE (Left)			
Time, Location, Activity, Treatment			
Pain	Buckling	Burning	Crackling

KNEE (Right)			
Time, Location, Activity, Treatment			
Pain	Buckling	Burning	Crackling

Explain your balance while standing on one leg at a time: _____
Have you taken acoustic wave therapy: _____ no _____ yes (state benefit): _____
Are you currently enrolled in Cognitive Behavioral Therapy (CBT) for Chronic Pain: _____ no _____ yes
(state benefit): _____

Would you like to partake in genetic testing related to muscular, skeletal, or metabolic disorders: _____ no _____ yes