



14198

# Sports Knee Patient History

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Medical Record Number

10 digit grid for Medical Record Number

Date of Visit

MM/DD/YYYY grid for Date of Visit

First Name

15 digit grid for First Name

Middle

3 digit grid for Middle

Last Name

20 digit grid for Last Name

Suffix  Sr.  Jr.  III  IV  M.D.  PhD

Date of Birth

MM/DD/YYYY grid for Date of Birth with labels: month, day, year (4 digit ex. 1922)

Gender

Female  Male

Race

African American  Asian  Caucasian  Hispanic  Native American  Other \_\_\_\_\_

Marital Status

Single  Married  Living with significant other  Divorced  Separated  Widowed

Location of Problem

Right knee  Left knee

If you are seeing us for more than one problem, which ONE is the worst?

Right knee  Left knee

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)

- New Injury or problem (less than 6 weeks duration)
- Subacute problem (began slowly with no identifiable cause and progressively worsened)
- Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
- Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)

MM/DD/YYYY grid for Date problem began

Date of re-injury

MM/DD/YYYY grid for Date of re-injury

Is your problem a result of an injury?  Yes  No

### ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

Home  Work  Motor vehicle accident  Exercise  Sport Competition  Other (specify) \_\_\_\_\_

What caused your injury?

- Fall  Fighting
- Lifting  Twisting
- Throwing  Collision/Contact
- Reaching  Other (specify) \_\_\_\_\_
- Pulling

Check any of the following that happened at the time of your injury

Felt pain  Heard popping  Had swelling  Dislocation  Fracture  Other (specify) \_\_\_\_\_

Have you talked to a lawyer about today's problem?  Yes  No

Are you receiving or have you applied for workers compensation concerning your injury?  Yes  No

Have you received previous treatment for your current problem?  Yes  No

If yes, please specify treatment type (**check all that apply**) and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today

- ER Visit  chiropractic
- oral medicine  massage therapy
- physical therapy # of weeks   acupuncture
- surgical # of surgeries   other \_\_\_\_\_
- injections # of injections  (specify)

Please tell us your height and weight

Height

ft  inches

Weight

pounds





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·Please check any of the following conditions you have or have had in the past.  
·If you are unsure, please ask a staff member to assist you in filling out this form.

**You may check more than one condition.**

**Medical Condition History** Check this box if you have **no** medical problems  no medical problems

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> GERD  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Gout  |
| <input type="checkbox"/> Arthritis - rheumatoid (verified with blood test)  | <input type="checkbox"/> Heart Attack Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Arthritis - osteo, degenerative  | <input type="checkbox"/> Hypertension (High Blood Pressure)  |
| <input type="checkbox"/> Blood Clot Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>        | <input type="checkbox"/> Hypercholesterolemia (Elevated Cholesterol)   |
| <input type="checkbox"/> Blood Transfusion Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Hypothyroidism  |
| <input type="checkbox"/> Bowel disease  | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Cancer (specify) _____   | <input type="checkbox"/> Liver Disorder - Cirrhosis  |
| <input type="checkbox"/> Cardiac Arrhythmia (Abnormal heart rate)   | <input type="checkbox"/> Liver Disorder - Hepatitis  |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> Lung Disease  |
| <input type="checkbox"/> Coronary Artery Disease (Angina)   | <input type="checkbox"/> Osteomyelitis   |
| <input type="checkbox"/> Cerebrovascular Disease (Stroke)   | <input type="checkbox"/> Parkinson's   |
| <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)   | <input type="checkbox"/> Ulcer Disease   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Other (specify all other) _____   |

**Surgery/ Procedures** These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

**Have you ever had surgery?**  Yes  No

|   | <u>Year</u>   |
|---|---|
| <b><u>Ear, Nose, Throat Procedures</u></b>  |   |
| <input type="checkbox"/> Deviated Septum -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Sinus Repair -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Tonsillectomy -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Tracheostomy -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Vocal Cord Surgery -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Gastrointestinal Procedures</u></b>   |   |
| <input type="checkbox"/> Appendectomy -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Cholecystectomy (Gallbladder removed) -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Colon Resection -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Exploratory Laparoscopy -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Hernia -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="radio"/> Femoral <input type="radio"/> Incisional <input type="radio"/> Inguinal <input type="radio"/> Umbilical |   |
| <input type="checkbox"/> Liver Resection -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Small Bowel Obstruction Repair -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Splenectomy -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Gynecologic Procedures</u></b>  |   |
| <input type="checkbox"/> Hysterectomy -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Oophorectomy -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Ruptured ectopic -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Laparoscopy -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> C-Section -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Urologic Procedures</u></b>   |   |
| <input type="checkbox"/> Bladder Suspension -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Bladder Removed -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Lithotripsy (Stone Machine) -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Prostatectomy (Prostate Removed) -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Vasectomy -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

|   | <u>Year</u>   |
|---|---|
| <b><u>General Procedures</u></b>  |   |
| <input type="checkbox"/> Breast Biopsy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----                                     | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Mastectomy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Thyroid Surgery -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Whipple -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Heart (Cardiac) Procedures</u></b>  |   |
| <input type="checkbox"/> CABG # arteries <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 4+ ----- | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Valve <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral <input type="checkbox"/> Tricuspid -----                                 | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Angioplasty -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Defibrillator -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Pace Maker -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Vascular Procedures</u></b>   |   |
| <input type="checkbox"/> Bypass Graft - Legs -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Vascular Access -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> AAA -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Thoracic Aneurysm -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Thoracic Procedures</u></b>   |   |
| <input type="checkbox"/> Chest Tube -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Pulmonary -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Pectus -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <b><u>Neurologic Procedures</u></b>   |   |
| <input type="checkbox"/> Brain Tumor <input type="radio"/> Malignant <input type="radio"/> Benign -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Brain Aneurysm -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Chiari Decompression -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Spinal Cord Tumor <input type="radio"/> Malignant <input type="radio"/> Benign -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Epidural Injection -----   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Abscess -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Stent -----  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |



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### Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

**Most Recent Year**

**Previous Surgery Year**

(if same surgery performed more than once)

#### **Broken Bones/Fracture Repair**

- Fracture Repair - Finger -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Hand -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Wrist -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Arm -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Elbow -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Shoulder -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Hip/Pelvis -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Femur -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Knee -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Lower Leg -----  Right  Left  Bilateral ----- 

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- Fracture Repair - Ankle/Foot -----  Right  Left  Bilateral ----- 

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#### **Ankle/Foot Procedures**

- Ankle Arthroscopy -----  Right  Left  Bilateral ----- 

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- Ankle Fusion -----  Right  Left  Bilateral ----- 

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- Tendon Surgery -----  Right  Left  Bilateral ----- 

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- Toe Surgery specify \_\_\_\_\_ -----  Right  Left  Bilateral ----- 

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#### **Elbow, Wrist, Hand Procedures**

- Biceps Repair -----  Right  Left  Bilateral ----- 

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- Carpal Tunnel Surgery -----  Right  Left  Bilateral ----- 

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- Elbow Arthroscopy -----  Right  Left  Bilateral ----- 

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- Elbow Ligament Reconstruction -----  Right  Left  Bilateral ----- 

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- Elbow Replacement -----  Right  Left  Bilateral ----- 

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- Hand Tendon Repair -----  Right  Left  Bilateral ----- 

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- Nail Bed Surgery -----  Right  Left  Bilateral ----- 

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- Tennis Elbow Surgery -----  Right  Left  Bilateral ----- 

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- Trigger Finger Surgery -----  Right  Left  Bilateral ----- 

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- Wrist Ligament Reconstruction -----  Right  Left  Bilateral ----- 

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#### **Knee Procedures**

- Knee Arthroscopy -----  Right  Left  Bilateral ----- 

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- Cartilage surgery/meniscus surgery -----  Right  Left  Bilateral ----- 

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- Knee replacement -----  Right  Left  Bilateral ----- 

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- Ligament reconstruction - ACL -----  Right  Left  Bilateral ----- 

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- Ligament reconstruction - other -----  Right  Left  Bilateral ----- 

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#### **Hip Procedures**

- Hip replacement -----  Right  Left  Bilateral ----- 

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- AVN Surgery  Core Decompression  Fibular Graft  Right  Left  Bilateral ----- 

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#### **Shoulder Procedures**

- Shoulder Arthroscopy -----  Right  Left  Bilateral ----- 

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- Rotator cuff surgery -----  Right  Left  Bilateral ----- 

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- Shoulder replacement -----  Right  Left  Bilateral ----- 

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- Shoulder stabilization -----  Right  Left  Bilateral ----- 

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#### **Spine Procedures**

- Laminectomy -----  Cervical  Lumbar  Thoracic ----- 

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- Anterior Fusion -----  Cervical  Lumbar  Thoracic ----- 

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- Posterior Fusion -----  Cervical  Lumbar  Thoracic ----- 

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- Posterior Discectomy -----  Cervical  Lumbar  Thoracic ----- 

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**Other** (List all other surgeries) \_\_\_\_\_







14198

Hand Dominance:  Right  Left  Use both equally

## Knee - IKDC

### SYMPTOMS\*

\*Grade symptoms at the highest level of activity at which you think you could function without significant symptoms, even if you are not actually performing activities at this level. Check **ONLY ONE** answer for each question.

How would you rate your knee today as a percentage of normal (0% - 100%, with 100% being normal)?    %

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

- Very strenuous activities like jumping or pivoting as in basketball or soccer
- Strenuous activities like heavy physical work, skiing or tennis
- Moderate activities like moderate physical work, running or jogging
- Light activities like walking, housework, or yard work
- 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? **(PLEASE MARK A NUMBER)**

- 0    1    2    3    4    5    6    7    8    9    10  
 never constant

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

- not at all    mildly    moderately    very    extremely

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

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

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

- Yes    No

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

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



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SPORTS ACTIVITIES

Check **ONLY ONE** answer for each question

8. What is the highest level of activity you can participate in on a regular basis?

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

9. How does your knee affect your ability to:

|                                    | <u>Not difficult<br/>at all</u> | <u>Minimally<br/>difficult</u> | <u>Moderately<br/>difficult</u> | <u>Extremely<br/>difficult</u> | <u>Unable to<br/>do so</u> |
|------------------------------------|---------------------------------|--------------------------------|---------------------------------|--------------------------------|----------------------------|
| Go up stairs                       | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Go down stairs                     | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Kneel on the front of your knee    | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Squat                              | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Sit with your knee bent            | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Rise from a chair                  | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Run straight ahead                 | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Jump and land on your involved leg | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |
| Stop and start quickly             | <input type="radio"/> 5         | <input type="radio"/> 4        | <input type="radio"/> 3         | <input type="radio"/> 2        | <input type="radio"/> 1    |

10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities?

Function **prior to** your knee injury: (PLEASE MARK A NUMBER)

- 0    1    2    3    4    5    6    7    8    9    10  
 cannot perform daily activities No limitation

Current function of your knee: (PLEASE MARK A NUMBER)

- 0    1    2    3    4    5    6    7    8    9    10  
 cannot perform daily activities No limitation



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**SF-12 - Check ONLY ONE answer for each question**

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

**(#2 and #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?

- |  | <u>Yes,</u><br>Limited<br><u>A Lot</u> | <u>Yes,</u><br>Limited<br><u>A Little</u> | <u>No, Not</u><br>Limited<br><u>At All</u> |
|--|--|---|--|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1                | <input type="radio"/> 2                   | <input type="radio"/> 3                    |
| 3. Climbing several flights of stairs  | <input type="radio"/> 1                | <input type="radio"/> 2                   | <input type="radio"/> 3                    |

**(#4 and #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 your physical health?

- |   | <u>Yes</u>              | <u>No</u>               |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like                | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

**(#6 and #7)** 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)?

- |   | <u>Yes</u>              | <u>No</u>               |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like                            | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

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

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

**(#9, #10 and #11)** 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

- |   | <u>All</u><br>of the<br><u>time</u> | <u>Most</u><br>of the<br><u>time</u> | <u>A good</u><br>bit of<br><u>time</u> | <u>Some</u><br>of the<br><u>time</u> | <u>A little</u><br>of the<br><u>time</u> | <u>None</u><br>of the<br><u>time</u> |
|---|-------------------------------------|--------------------------------------|--|--------------------------------------|--|--------------------------------------|
| 9. Have you felt calm and peaceful?     | <input type="radio"/> 1             | <input type="radio"/> 2              | <input type="radio"/> 3                | <input type="radio"/> 4              | <input type="radio"/> 5                  | <input type="radio"/> 6              |
| 10. Did you have a lot of energy?       | <input type="radio"/> 1             | <input type="radio"/> 2              | <input type="radio"/> 3                | <input type="radio"/> 4              | <input type="radio"/> 5                  | <input type="radio"/> 6              |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1             | <input type="radio"/> 2              | <input type="radio"/> 3                | <input type="radio"/> 4              | <input type="radio"/> 5                  | <input type="radio"/> 6              |

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

- |  | <u>All</u><br>of the<br><u>time</u> | <u>Most</u><br>of the<br><u>time</u> | <u>Some</u><br>of the<br><u>time</u> | <u>A little</u><br>of the<br><u>time</u> | <u>None</u><br>of the<br><u>time</u> |
|--|-------------------------------------|--------------------------------------|--------------------------------------|--|--------------------------------------|
|  | <input type="radio"/> 1             | <input type="radio"/> 2              | <input type="radio"/> 3              | <input type="radio"/> 4                  | <input type="radio"/> 5              |

**PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW**