KOOS KNEE SURVEY

Name: _____ Date: _____

This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities. Answer every question by circling the appropriate number, only one number for each. If you are unsure about <u>how to answer</u>, please give the best answer you can.

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	SYMPTOMS: These questions should be answered about your knee					
	symptoms during the last week?	EVER	RARELY	SOMETIMES	OFTEN	ALWAYS
S1	Do you have swelling in your knee?	0	1	2	3	4
S2	Do you feel grinding, hear clicking or any other type of noise when your knee moves?	0	1	2	3	4
S3	Does your knee catch or hang up when moving?	0	1	2	3	4
S4	Can you straighten your knee fully?	0	1	2	3	4
S5	Can you bend your knee fully?	0	1	2	3	4
	STIFFNESS: These questions concern the amount of joint stiffness you have experienced during the last week? (Stiffness is a sensation of restriction or slowness in the ease of movement)	NONE	MILD	MODERATE	SEVERE	EXTREME
S6	How severe is your knee joint stiffness after first wakening in the morning?	0	1	2	3	4
S7	How severe is your knee stiffness after sitting, lying or resting later in the day?	0	1	2	3	4
PI	How often do you experience knee pain? (circle appropriate response)	NEVER	MONTHLY	WEEKLY	DAILY	ALWAYS
	To be completed by therapist: 100- (TOTAL SCORE X 100/28) SYMPTOMS SCORE:					
	PAIN; What amount of knee pain have you experienced the last week during the following activities?	NONE	MILD	MODERATE	SEVERE	EXTREME
P2	Twisting/pivoting on your knee	0	1	2	3	4
P3	Straightening knee fully	о	1	2	3	4
P4	Bending knee fully	0	1	2	3	4
PS	Walking on flat surface	0	1	2	3	4
PG	Going up or down stairs	0	1	2	3	4
P7	At night while in bed	0	1	2	3	4
P8	Sitting or lying	' O	1	2	3	4
P9	Standing upright	0	1	2	3	4
	To be completed by therapist: 100 (TOTAL SCORE X 100/36) PAIN SCORE:					

KOOS KNEE SURVEY, continued

	FUNCTION/DAILY LIVING: These questions concern your ability to move around and to look	NONE	MILD	MODERATE	SEVERE	EXTREME
	after yourself. Please indicate the degree of difficulty you have experienced in the last week.					
AI	Descending stairs	0	1	2	3	4
A2	Ascending stairs	0	1	2	3	4
A3	Rising from sitting	0	1	2	3	4
A4	Standing	0	1	2	3	4
AS	Bending to floor/pick up object	0	1	2	3	4
A6	Walking on flat surface	0	1	2	3	4
A7	Getting in/out of car	0	1	2	3	4
A8	Going shopping	0	1	2	3	4
A9	Putting on socks/stockings	0	1	2	3	4
Al0	Rising from bed	0	1	2	3	4
All	Taking off socks/stockings	0	1	2	3	4
A12	Lying in bed (turning over, maintaining knee position)	0	1	2	3	4
A13	Getting in/out of bath	0	1	2	3	4
A14	Sitting or lying	0	1	2	3	4
AI5	Getting on/off toilet	0	1	2	3	4
A16	Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)	0	1	2	3	4
A17	Light domestic duties (cooking, dusting, etc.)	0	1	2	3	4
	To be completed by therapist: 100 - (TOTAL SCORE X 100/68) AOL SCORE:			·	·	
	FUNCTION, SPORTS & RECREATIONAL ACTIVITIES: The following questions concern your					
	physical function when being active on a higher level. The questions should be answered					
SP1	thinking of what degree of difficulty you have experienced the last week due to your knee. Squatting	NONE 0	MILD 1	MODERATE 2	SEVERE 3	EXTREME 4
SP1 SP2	Running	0	1	2	3	4
SP2	Jumping	0	1	2	3	4
SP4	Twisting/pivoting on your injured knee	0	1	2	3	4
SPS	Kneeling	0	1	2	3	4
	To be completed by therapist: 100 -(TOTAL SCORE X 100/20) SPORTS SCORE:		L	1	1	1

THE LOWER EXTREMITY FUNCTIONAL SCALE

NAME:

DATE:

onnaire has been designed to give the doctor/physical therapist information as to how your lower limb has affected your ability to manage in daily life. Please answer

Ę	This questionnaire has been designed to give the decorption the appropriate response. Please only i	Please only ma	Please only mark ONE response per question.	er question.			
	every question by circling the number born and a second se	EXTREME DIFFICULTY OR UNABLE TO	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY	
	Today, do you or would you have any difficulty at all with:	PERFORM	-	2	e B	4	
1	Any of your usual work, housework, or school activities.		. 1	2	ю	4	15
2	Your usual hobbies, recreational or sporting activities.			2	ñ	4	
m	Getting into or out of the bath.		ı	2	3	4	
4	Walking between rooms.		1	2	ю	4	
S	Putting on your shoes or socks.		1	2	3	4	
9	Squatting.		-	2	£	4	
~	Lifting an object, like a bag of groceries from the floor.		4 -	2	3	4	
8	Performing light activities around your home.		4 -	2	ю	4	
6	Performing heavy activities around your home.	0 0	4 -		ŝ	4	
10	Getting into or out of the car.	0 0	4 -	2	ŝ	4	
11	Walking 2 blocks.	0 0	4 –	- 7	£	4	
12	Walking 1 mile.		4 -	2	3	4	
13	Going up or down 10 stairs (about 1 flight of stairs).			2	ß	4	
14	Standing for 1 hour.		1	2	3	4	
15	Sitting for 1 hour.		1	2	3	4	
16	Running on even ground.		1	2	e	4	
17	Running on uneven ground.			2	m	4	
18	Making sharp turns while running fast.			2	e	4	1
19	Hopping.			2	3	4	
20	Rolling over in bed.	>					
]	To be completed by physical therapist/provider only		SCORE:	/8	80		