# KNEE OUTCOME SURVEY ACTIVITIES OF DAILY LIVING SCALE

**Section 1: To be completed by patient**

Name:_____ Age: _____ Date of Birth: _____ Today's Date:_____

Height _____ ft. _____ in. Weight_____lbs.

Occupation: _____ Onset of knee pain: _____ (this episode)

**Section 2: To be completed by patient**

**To what degree does each of the following symptoms affect your level of daily activity?**

| | Never Have | Have, but does not affect activity | Affects activity slightly | Affects activity moderately | Affects activity severely | Prevents me from all daily activity |
|---|---|---|---|---|---|---|
| Pain | 5 | 4 | 3 | 2 | 1 | 0 |
| Grinding or Grating | 5 | 4 | 3 | 2 | 1 | 0 |
| Stiffness | 5 | 4 | 3 | 2 | 1 | 0 |
| Swelling | 5 | 4 | 3 | 2 | 1 | 0 |
| Slipping or Partial Giving Way of Knee | 5 | 4 | 3 | 2 | 1 | 0 |
| Buckling or Full Giving Way of Knee | 5 | 4 | 3 | 2 | 1 | 0 |
| Weakness | 5 | 4 | 3 | 2 | 1 | 0 |
| Limping | 5 | 4 | 3 | 2 | 1 | 0 |

**How does your knee affect your ability to… (check one number on each line)**

| | Not difficult at all | Minimally difficult | Somewhat difficult | Fairly difficult | Very difficult | Unable to do |
|---|---|---|---|---|---|---|
| Walk | 5 | 4 | 3 | 2 | 1 | 0 |
| Go upstairs | 5 | 4 | 3 | 2 | 1 | 0 |
| Go downstairs | 5 | 4 | 3 | 2 | 1 | 0 |
| Stand | 5 | 4 | 3 | 2 | 1 | 0 |
| Kneel on the front of your knee | 5 | 4 | 3 | 2 | 1 | 0 |
| Squat | 5 | 4 | 3 | 2 | 1 | 0 |
| Sit up with your knee bent | 5 | 4 | 3 | 2 | 1 | 0 |
| Rise from a chair | 5 | 4 | 3 | 2 | 1 | 0 |

**Section 3: To be completed by physical therapist/provider SCORE: ____/80 x 100 ____% (SEM 9.7, MEDC 8.4)**

**SCORE: Initial _____ Subsequent _____ Subsequent _____ Discharge**

**Number of treatment sessions:** _____

**Diagnosis/ICD-9 Code:** _____