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: _____