

## KNEE OUTCOME SURVEY ACTIVITIES OF DAILY LIVING SCALE

### Section 1: To be completed by patient

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 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?  
 (circle one number on each line)

|  | Never Have | Have, but does not affect activity | Affects activity slightly | Affects activity moderately | Affects activity severely | Prevent 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...(circle 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              |              |
| Go up stairs                    | 5                    | 4                   | 3                  | 2                | 1              | 0            |
| Go down stairs                  | 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 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 3.7, MDC 8.4)

SCORE: Initial \_\_\_\_\_ Subsequent \_\_\_\_\_ Subsequent \_\_\_\_\_ Discharge \_\_\_\_\_

Number of treatment sessions: \_\_\_\_\_

Diagnosis/ICD-9 Code: \_\_\_\_\_