

## 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?**

	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...(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	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: \_\_\_\_\_**