



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 9.7, MDC 8.4)

SCORE: Initial _____ Subsequent _____ Subsequent _____ Discharge _____

Number of treatment sessions: _____

Diagnosis/ICD-9 Code: _____

adapted from Irrgang JJ, et al. Development of a patient-reported measure of function of the knee. J Bone Joint Surg Am. 1998; 80: 1132-1145.