

## 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: \_\_\_\_\_**

# The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please **CIRCLE** an answer for **EACH** activity on the scale.

Today, do you or would you have any difficulty at all with...		Extremely Difficulty/Unable	Quite a bit of difficulty	Moderate Difficulty	Little Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4