



KNEE SURVEY



Last Name _____ First Name _____ Date ____ / ____ / ____

CURRENT PROBLEM

Is your problem in the: Right knee Left knee Both knees

What is the problem with your knee?

When did the problem start? ____ / ____ / ____ Did it start: Gradually Suddenly

Is your problem getting: Worse Better Staying the same

Was this a result of an injury? Yes No

If yes, please describe how it happened: _____

Rate the overall condition of your knee at the present time. Check only one box below.

0 1 2 3 4 5 6 7 8 9 10
cannot perform poor fair good normal
daily activities

poor- Have significant limitations that affect activities of daily living.
fair- Have moderate limitations that affect activities of daily living, no sports possible.
good- Have some limitations with sports but I can participate; I compensate.
normal/excellent- Able to do whatever I wish (any sport) with no problems.

Rate the function of your knee prior to your injury.

0 1 2 3 4 5 6 7 8 9 10
cannot perform poor fair good normal
daily activities

PAIN QUESTIONS

Are you having pain in your knee? Yes No Location of pain: Inner side Back of knee
 Front/kneecap All over
 Outer side

How often do you experience pain? Never Monthly Weekly Daily Always

During the past 4 weeks, or since your injury, how **often** have you had **pain**?

Never 0 1 2 3 4 5 6 7 8 9 10 Constant

How **severe** is your pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Describe your pain (check one):

Constant
 Comes and goes

Describe your pain (check all that apply):

Dull Sharp Burning
 Throbbing Aching

For office use only

Bach Bush-Joseph Cole _____
 M F WC: Y N

--	--	--	--	--	--

KNEE SYMPTOMS

Do you experience buckling or giving-way of your knee?

- No, never
- Yes, rarely during sporting activities or other severe exertion
- Yes, frequently during sporting activities or other severe exertion
- Yes, occasionally during daily activities
- Yes, frequently during daily activities
- Yes, on every step

Do you have swelling in your knee?

- Never Often
- Rarely Always
- Sometimes

During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

- Not at all Very
- Mildly Extremely
- Moderately

What is the highest level of activity you can perform **without** significant **swelling** in your knee?

- Very strenuous** like jumping or pivoting as in basketball or soccer
- Strenuous** activities like heavy physical work, skiing or tennis
- Moderate** activities like moderate physical work, running or jogging
- Light** activities like walking, housework, or yard work
- Unable** to perform any of the above activities due to knee swelling

What is the highest level of activity you can perform **without** significant **giving-way** in your knee?

- Very strenuous** like jumping or pivoting as in basketball or soccer
- Strenuous** activities like heavy physical work, skiing or tennis
- Moderate** activities like moderate physical work, running or jogging
- Light** activities like walking, housework, or yard work
- Unable** to perform any of the above activities due to knee swelling

What is the highest level of activity you can perform **without** significant knee **pain**?

- Very strenuous** like jumping or pivoting as in basketball or soccer
- Strenuous** activities like heavy physical work, skiing or tennis
- Moderate** activities like moderate physical work, running or jogging
- Light** activities like walking, housework, or yard work
- Unable** to perform any of the above activities due to knee swelling

How severe is your knee **stiffness** after waking in the **morning**?

- None Severe
- Mild Extreme
- Moderate

How severe is your knee **stiffness** after sitting, lying or resting **later in the day**?

- None Severe
- Mild Extreme
- Moderate

Do you feel **grinding**, hear **clicking** or any other type of noise when your knee moves?

- Never Often
- Rarely Always
- Sometimes

Does your knee **catch or lock** when moving?

- Never Often
- Rarely Always
- Sometimes

For office use only

Reviewed by _____ MD Date _____

--	--	--	--	--	--	--

ACTIVITIES OF DAILY LIVING

For each of the following activities, please indicate the degree of difficulty you have experienced in the last week due to your knee.

	None	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Extreme Difficulty
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on flat surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting with knee bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying in bed (turning over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on socks/stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking off socks/stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting on/off toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy housework (scrubbing floors, moving heavy boxes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light housework (cooking, dusting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling on the front of your knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending to floor/pick up an object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Full squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For office use only

Reviewed by _____ MD Date _____

--	--	--	--	--	--

What statement best describes the way that you walk?

- I never walk with a limp
- I rarely walk with a limp or I walk with a slight limp
- I walk with a constant and severe limp

Do you presently use a support while you walk?

- I can walk without crutches or a cane
- I can put some weight on my leg, but I need at least one crutch or a cane to walk
- I cannot put any weight on my leg while walking

Can you **straighten** your knee fully?

- Always
- Often
- Sometimes
- Rarely
- Never

Can you **bend** your knee fully?

- Always
- Often
- Sometimes
- Rarely
- Never

SPORTS FUNCTION

Select **one** category (A,B,C or D) that indicates how often you participate in sports, then choose the one box that best describes the type of activities you do. Select one box to describe your activities *before* your knee injury and one for your *current* activities.

Before your knee injury

Currently

(choose one)

(choose one)

Category A (participate 4-7 days/week)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer) |
| <input type="checkbox"/> | <input type="checkbox"/> | Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling) |
| <input type="checkbox"/> | <input type="checkbox"/> | No running, twisting, jumping (cycling, swimming) |

Category B (participate 1-3 days/week)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer) |
| <input type="checkbox"/> | <input type="checkbox"/> | Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling) |
| <input type="checkbox"/> | <input type="checkbox"/> | No running, twisting, jumping (cycling, swimming) |

Category C (participate 1-3 times/month)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer) |
| <input type="checkbox"/> | <input type="checkbox"/> | Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling) |
| <input type="checkbox"/> | <input type="checkbox"/> | No running, twisting, jumping (cycling, swimming) |

Category D (no sports)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I perform activities of daily living without problems |
| <input type="checkbox"/> | <input type="checkbox"/> | I have moderate problems with activities of daily living |
| <input type="checkbox"/> | <input type="checkbox"/> | I have severe problems with activities of daily living; on crutches, full disability |

How much difficulty do you have currently with your injured knee while:

Running

Jumping

Stopping and Starting Quickly

Twisting/Pivoting

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Mild | <input type="checkbox"/> Mild | <input type="checkbox"/> Mild |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Moderate | <input type="checkbox"/> Moderate | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Severe | <input type="checkbox"/> Severe | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Unable/Haven't tried | <input type="checkbox"/> Unable/Haven't tried | <input type="checkbox"/> Unable/Haven't tried | <input type="checkbox"/> Extreme/Haven't tried |

For office use only

Reviewed by _____ MD Date _____

--	--	--	--	--	--	--

QUALITY OF LIFE

Does your knee allow you to sleep comfortably? Yes No

How often are you aware of your knee problem?

Never Monthly Weekly Daily Constantly

Have you modified your lifestyle to avoid potentially damaging activities to your knee?

Not at all Mildly Moderately Severely Totally

How much are you troubled with the lack of confidence in your knee?

Not at all Mildly Moderately Severely Totally

In general, how much difficulty do you have with your knee?

None Mild Moderate Severe Extreme

What have you used for your symptoms?

Did you get relief?

	Yes	No	Yes	No	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How long did you attend? _____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____

Does your kneecap (patella) feel like it's sliding out? Yes No

Has your kneecap ever dislocated? Yes No

If yes, how many times? _____

Dates of dislocations: _____

Treatment: _____

What tests have you already had concerning your knee problem?

- x-rays result: _____
- CT scan result: _____
- MRI result: _____
- EMG result: _____
- arthrogram result: _____
- other result: _____

For office use only

Reviewed by _____ MD Date _____

--	--	--	--	--	--	--

CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling anxious or depressed)?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all Quite a bit
- A little bit Extremely
- Moderately

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks:

	<u>All of the time</u>	<u>Most of the time</u>	<u>A good bit of the time</u>	<u>Some of the time</u>	<u>A little of the time</u>	<u>None of the time</u>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

Thank you for completing this information!

Reviewed by _____ MD Date _____

--	--	--	--	--	--	--