NAME:

DATE:

Knee Outcomes Survey

*How does your **knee** affect your ability to ...* (check **one** answer on each line – please do not skip any lines)

	Not difficult at all	Minimally Difficult	Somewhat Difficult	Fairly Difficult	Very Difficult	Unable to do
Walk						
Go up stairs						
Go down stairs						
Stand						
Kneel on the front of your knee						
Squat						
Sit with your knee bent						
Rise from the chair						

To what degree does each of the following symptoms affect your level of activity? (Check **one** answer each line)

	Never have	Have, but does not affect activity	Affects activity slightly	Affects activity moderately	Affects activity severely	Prevents me from all daily activity
Pain						
Grinding or grating						
Stiffness						
Swelling						
Slipping or partial giving way of the knee						
Buckling of full giving way of the knee						
Weakness						
Limping						

Scoring Therapist Only: Sum / 80 x 100=__________________%