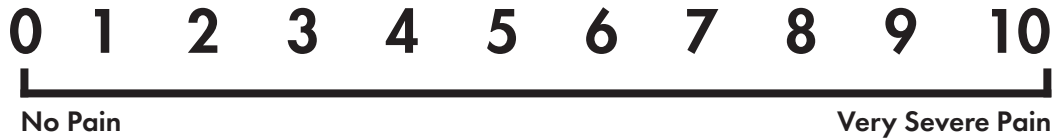


Knee Injury and Osteoarthritis Outcome Score (KOOS)



Name: _____ Date: _____

Please rate your pain level with activity:



INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities. Answer every question by marking the appropriate box, **only one** box for each question. If you are unsure about how to answer a question, please give the best answer you can.

SYMPTOMS: These questions should be answered thinking of your knee symptoms during the last week .	
S1. Do you have swelling in your knee?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always
S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always
S3. Does your knee catch or hang up when moving?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always
S4. Can you straighten your knee fully?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always
S5. Can you bend your knee fully?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always

STIFFNESS: The following questions concern the amount of joint stiffness you have experienced during the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.	
S6. How severe is your knee joint stiffness after first wakening in the morning?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
S7. How severe is your knee stiffness after sitting, lying or resting later in the day?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

PAIN:	
P1. How often do you experience knee pain?	<input type="checkbox"/> Never <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Always
What amount of knee pain have you experienced the last week during the following activities?	
P2. Twisting/pivoting on your knee	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P3. Straightening knee fully	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P4. Bending knee fully	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P5. Walking on flat surface	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

Knee Injury and Osteoarthritis Outcome Score (KOOS)



PAIN: Continued... What amount of knee pain have you experienced the last week during the following activities?

P6. Going up or down stairs	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P7. At night while in bed	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P8. Sitting or lying	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
P9. Standing upright	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

FUNCTION, DAILY LIVING: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A2. Ascending stairs	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
For each of the following activities please indicate the degree of difficulty you have experienced in the last week due to your knee:	
A3. Rising from sitting	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A4. Standing	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A5. Bending to floor/pick up an object	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A6. Walking on flat surface	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A7. Getting in/out of car	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A8. Going shopping	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A9. Putting on socks/stockings	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A10. Rising from bed	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A11. Taking off socks/stockings	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A12. Lying in bed (turning over, maintaining knee position)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A13. Getting in/out of bath	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A14. Sitting	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A15. Getting on/off toilet	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A 16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
A 17. Light domestic duties (cooking, dusting, etc)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

Knee Injury and Osteoarthritis Outcome Score (KOOS)



FUNCTION, SPORTS & RECREATIONAL ACTIVITIES: The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
SP2. Running	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
SP3. Jumping	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
SP4. Twisting /pivoting on your injured knee	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
S5. Kneeling	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

QUALITY OF LIFE

Q1. How often are you aware of your knee problem?	<input type="checkbox"/> Never <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Constantly
Q2. Have you modified your life style to avoid potentially damaging activities to your knee?	<input type="checkbox"/> Not a All <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Extremely
Q3. How much are you troubled with lack of confidence in your knee?	<input type="checkbox"/> Not a All <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Extremely
Q4. In general, how much difficulty do you have with your knee?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

Thank you very much for completing all the questions in this questionnaire.