GREENCASTLE
PHYSICAL THERAPY & SPORTS MEDICINE

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 the 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	0
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 bent	5	4	3	2	1	0
Rising from chair	5	4	3	2	1	0