



Name: _____ Date: _____

Knee Injury and Osteoarthritis Outcome Score

INSTRUCTIONS:

This survey asks for your view about your knee. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.

Answer every question by checking the appropriate circle, only one box for each question. If you are uncertain about how to answer a question, please give the best answer you can.

Section A: Symptoms

INSTRUCTIONS: these questions should be answered thinking about your hip symptoms and difficulties during the **last week**.

Do you have swelling in your knee?	Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Often <input type="radio"/>	Always <input type="radio"/>
Do you feel grinding, hear clicking, or any other type of noise when your knee moves?	Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Often <input type="radio"/>	Always <input type="radio"/>
Does your knee catch or hang up when moving?	Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Often <input type="radio"/>	Always <input type="radio"/>
Can you straighten your knee fully?	Always <input type="radio"/>	Often <input type="radio"/>	Sometimes <input type="radio"/>	Rarely <input type="radio"/>	Never <input type="radio"/>
Can you bend your knee fully?	Always <input type="radio"/>	Often <input type="radio"/>	Sometimes <input type="radio"/>	Rarely <input type="radio"/>	Never <input type="radio"/>

INSTRUCTIONS: these 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.

How severe is your knee joint stiffness upon awakening in the morning ?	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
How severe is your knee joint stiffness after sitting, lying, or resting later in the day ?	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>

Section B: Pain

INSTRUCTIONS: these questions concern the amount of knee pain you have experienced in the **last week** during the following activities.

How often do you experience knee pain?	Never <input type="radio"/>	Monthly <input type="radio"/>	Weekly <input type="radio"/>	Daily <input type="radio"/>	Always <input type="radio"/>
Twisting/pivoting on your knee	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Straightening your knee fully	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Bending your knee fully	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Walking on a flat surface	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Going up or down stairs	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
At night while in bed	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Sitting or lying down	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>
Standing upright	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>

Section C: Physical Function

INSTRUCTIONS: the following questions concern your physical function. By this we mean your ability to move around and 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.

	Never	Mild	Moderate	Severe	Extreme
Descending stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ascending stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising from sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending to the floor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking on a flat surface	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of the car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Putting on socks/stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Going shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising from bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking off socks/stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying in bed (turning over, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of the bath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting on/off the toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heavy domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section D: Function, Sports & Recreational activities

INSTRUCTIONS: 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.

	Never	Mild	Moderate	Severe	Extreme
Squatting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jumping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Twisting/pivoting on your knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kneeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section E: Quality of Life

How often are you aware of your knee problem?	Never <input type="radio"/>	Monthly <input type="radio"/>	Weekly <input type="radio"/>	Daily <input type="radio"/>	Constantly <input type="radio"/>
Have you modified your lifestyle to avoid activities potentially damaging to your knee?	Not at all <input type="radio"/>	Mildly <input type="radio"/>	Moderately <input type="radio"/>	Severely <input type="radio"/>	Totally <input type="radio"/>
How much are you troubled by lack of confidence in your knee?	Not at all <input type="radio"/>	Mildly <input type="radio"/>	Moderately <input type="radio"/>	Severely <input type="radio"/>	Extremely <input type="radio"/>
In general, how much difficulty do you have with your knee?	None <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Extreme <input type="radio"/>

Lower Extremity Activity Scale

Please read through each description given below, pick the ONE description that best describes your regular daily activity, and put a check in that circle (check one circle only).

- I am confined to bed all day.
- I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.)
- I am either in bed or sitting in a chair most of the day
- I sit most of the day, except for minimal transfer activities, no walking or standing.
- I sit most of the day, but I stand occasionally and walk a minimal amount in my house. (I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation.)
- I walk around my house to a moderate degree, but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment.
- I walk around my house, go outside at will and walk several blocks at a time.
- I walk around my house, go outside at will and walk several blocks at a time without any assistance (whether permitting).
- I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (whether permitting).

I am up and about at will in my house and outside. I also work outside the house in a:

- Minimally active job
- Moderately active job
- Extremely active job

(Please check the best description of your work level.)

I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, or swimming:

- Occasionally (2-3 times per month)
- 2-3 times per week
- Daily

I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports:

- Occasionally (2-3 times per month)
- 2-3 times per week
- Daily

Knee Society Score

Please answer the following questions:

Pain:

- None
- Mild – occasional
- Mild (stairs only)
- Mild (walking and stairs)
- Moderate – occasional
- Moderate – continual
- Severe

Activities:

Distance Walked:

- Unlimited
- More than 10 blocks
- 5-10 blocks
- Less than 5 blocks
- Housebound
- Unable

Stairs:

- Normal – up and down
- Normal up, down with rail
- Up and down with rail
- Up with rail, down unable
- Unable

Walking Aids:

- None
- Cane/walking stick
- Two canes/walking sticks
- Two crutches or walker



ORTHOPEDIC PARTNERS

Date: _____ Date of Injury: _____

Patient: _____ Place of Injury: _____

Provider: _____ Work Related? _____ Yes / _____ No

Account #: _____ Auto Accident: _____ Yes / _____ No

Insurance: _____ ID: _____

Subscriber: _____

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

_____ I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / _____ No

What did you injure? (example: left arm) _____

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including how and where it occurred as required by your insurance:

Signature _____ Witnessed _____

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