

KOS FORM

KNEE OUTCOME SURVEY

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

NAME: _____ **DATE OF BIRTH:** (MM/DD/YYYY) _____

DID YOU HAVE SURGERY FOR THIS ISSUE PRIOR TO RECEIVING PHYSICAL THERAPY? **YES – DATE:** (MM/DD/YYYY) _____ **NO**

DID YOU HAVE SURGERY FOR THIS ISSUE DURING THE COURSE OF RECEIVING PHYSICAL THERAPY? **YES – DATE:** (MM/DD/YYYY) _____ **NO**

PAIN SCORE: OVER THE PAST 24 HOURS, HOW BAD HAS YOUR PAIN BEEN?
CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR PAIN.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST IMAGINABLE PAIN**

TO WHAT DEGREE DOES EACH OF THE FOLLOWING SYMPTOMS AFFECT YOUR LEVEL OF ACTIVITY?
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	I DO NOT HAVE THIS SYMPTOM	I HAVE THE SYMPTOM, BUT IT DOES NOT AFFECT MY ACTIVITY	THE SYMPTOM AFFECTS MY ACTIVITY SLIGHTLY	THE SYMPTOM AFFECTS MY ACTIVITY MODERATELY	THE SYMPTOM AFFECTS MY ACTIVITY SEVERELY	THE SYMPTOM PREVENTS ME FROM ALL DAILY ACTIVITY
1. PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. STIFFNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. KNEE GIVES WAY: BUCKLING OR SHIFTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. LIMPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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FUNCTIONAL LIMITATIONS WITH ACTIVITIES - HOW DOES YOUR KNEE AFFECT YOUR ABILITY TO:
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	ACTIVITY IS NOT DIFFICULT	ACTIVITY IS MINIMALLY DIFFICULT	ACTIVITY IS SOMEWHAT DIFFICULT	ACTIVITY IS FAIRLY DIFFICULT	ACTIVITY IS VERY DIFFICULT	I AM UNABLE TO DO THE ACTIVITY
7. WALK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. GO UP STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. GO DOWN STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. STAND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. KNEEL ON FRONT OF YOUR KNEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. SQUAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. SIT WITH YOUR KNEE BENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. RISE FROM A CHAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>