

Patient name _____	Date of visit _____	Involved knee <input type="checkbox"/> right <input type="checkbox"/> left	Date of original injury _____
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DIRECTIONS:

Using the KEY (at right), check the appropriate boxes on the four scales below which indicate the highest level you can reach WITHOUT having symptoms.

KEY:

Scale Description

- 10 Normal knee, able to do strenuous work/sports with jumping, hard pivoting
- 8 Able to do moderate work/sports with running, turning and twisting; symptoms with strenuous work/sports
- 6 Able to do light work/sports with no running, twisting or jumping; symptoms with moderate work/sports
- 4 Able to do activities of daily living alone; symptoms with light work/sports
- 2 Moderate symptoms (frequent, limiting) with activities of daily living
- 0 Severe symptoms (constant, not relieved) with activities of daily living

1. PAIN _____ / 10

10 ————— 8 ————— 6 ————— 4 ————— 2 ————— 0

2. SWELLING (actual fluid in the knee; obvious puffiness) _____ / 10

10 ————— 8 ————— 6 ————— 4 ————— 2 ————— 0

3. PARTIAL GIVING-WAY (partial knee collapse, no fall to the ground) _____ / 10

10 ————— 8 ————— 6 ————— 4 ————— 2 ————— 0

4. FULL GIVING-WAY (knee collapse occurs with actual falling to the ground) _____ / 10

10 ————— 8 ————— 6 ————— 4 ————— 2 ————— 0

Pain	Location of pain	<input type="checkbox"/> inner side	<input type="checkbox"/> outer side	<input type="checkbox"/> front / kneecap	<input type="checkbox"/> back of knee	<input type="checkbox"/> all over
	Type of pain	<input type="checkbox"/> sharp	<input type="checkbox"/> aching	<input type="checkbox"/> throbbing	<input type="checkbox"/> burning	
	Pain occurs on	<input type="checkbox"/> sitting	<input type="checkbox"/> standing	<input type="checkbox"/> stairs	<input type="checkbox"/> squatting	<input type="checkbox"/> running / jumping
	Pain relieved	<input type="checkbox"/> by not doing sports	<input type="checkbox"/> by limiting daily activities	<input type="checkbox"/> by rest / medications	<input type="checkbox"/> pain not relieved	
Kneecap grinding?		<input type="checkbox"/> yes <input type="checkbox"/> no		Knee stiffness? <input type="checkbox"/> yes <input type="checkbox"/> no		

Catching/ Locking

1. Check one box: yes no My knee **catches** -- it does not move for a few seconds but works out.
 2. Check one box: yes no My knee **locks** -- it does not move for five or more minutes at a time.

Work Activity

My job title is: _____ Work status: full time part time full duty light duty not working

When I work, I experience:
 no limitations mild limitations moderate limitations severe limitations

Exercise Program

In my exercise program, I am:
 making good progress slow progress, but better some problems with exercise exercise causes pain, problems doesn't apply

Follow-up Progress

Following my last visit, I am:
 making good progress slow progress, but better staying the same symptoms worse doesn't apply

Patient Grade

Rate the overall condition of your knee at the present time. Circle one number below.

1	2 poor	3	4 fair	5	6 good	7	8	9	10 normal
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poor -- I have significant limitations that affect activities of daily living.
fair -- I have moderate limitations that affect activities of daily living, no sports possible.
good -- I have some limitations with sports but I can participate; I compensate.
normal/excellent -- I am able to do whatever I wish (any sport) with no problems.

Average

Pain (x2) _____ + swelling _____ + partial giving way _____ + full giving way _____ Subtotal = _____ = _____

5

Sports Activity Scale

Check the box which describes your level of sports activity before your original knee injury. Then, check the box which describes your level of sports activity at this time.

BEFORE INJURY		CURRENT LEVEL			
<input type="checkbox"/>	100	<input type="checkbox"/>			
<input type="checkbox"/>	95	<input type="checkbox"/>			
<input type="checkbox"/>	90	<input type="checkbox"/>			
<input type="checkbox"/>	85	<input type="checkbox"/>			
<input type="checkbox"/>	80	<input type="checkbox"/>			
<input type="checkbox"/>	75	<input type="checkbox"/>			
<input type="checkbox"/>	65	<input type="checkbox"/>			
<input type="checkbox"/>	60	<input type="checkbox"/>			
<input type="checkbox"/>	55	<input type="checkbox"/>			
<input type="checkbox"/>	40	<input type="checkbox"/>			
<input type="checkbox"/>	20	<input type="checkbox"/>			
<input type="checkbox"/>	0	<input type="checkbox"/>			

- Level I (participates 4-7 days/week)**
 Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer)
 Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling)
 No running, twisting, jumping (cycling, swimming)
- Level II (participates 1-3 days/week)**
 Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer)
 Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling)
 No running, twisting, jumping (cycling, swimming)
- Level III (participates 1-3 times/month)**
 Jumping, hard pivoting, cutting (basketball, volleyball, football, gymnastics, soccer)
 Running, twisting, turning (tennis, racquetball, handball, ice hockey, field hockey, skiing, wrestling)
 No running, twisting, jumping (cycling, swimming)
- Level IV (no sports)**
 I perform activities of daily living without problems
 I have moderate problems with activities of daily living
 I have severe problems with activities of daily living; on crutches, full disability

Highest Level (before injury) _____ / 100
 Highest Level (current) _____ / 100

Change in Sports Activities

Check the box which best describes any change you have had in sports activities since your injury / surgery.
 My sports activities have:

- | | | |
|---|--|---|
| <p>Not Changed
 <i>If yes, check one box below:</i>
 <input type="checkbox"/> I have no / slight problems (c)
 <input type="checkbox"/> I have moderate / significant problems (d)</p> | <p>Decreased
 <i>If yes, check one box below:</i>
 <input type="checkbox"/> I now have no / slight problems (e)
 <input type="checkbox"/> I now have moderate / significant problems (d)
 <input type="checkbox"/> For reasons not related to my knee (g)</p> | <p>Stopped – given up all sports
 <i>If yes, check one box below:</i>
 <input type="checkbox"/> I have moderate / significant problems when I play sports (f)
 <input type="checkbox"/> For reasons not related to my knee (g)</p> |
|---|--|---|

Level _____

Function ADL

Check the problems you have during:

- | | | |
|--|---|---|
| <p>1. Walking
 <i>check one box:</i>
 40 <input type="checkbox"/> normal, unlimited
 30 <input type="checkbox"/> some limitations
 20 <input type="checkbox"/> only 3-4 blocks possible
 0 <input type="checkbox"/> less than 1 block; cane, crutch</p> | <p>2. Stairs
 <i>check one box:</i>
 40 <input type="checkbox"/> normal, unlimited
 30 <input type="checkbox"/> some limitations
 20 <input type="checkbox"/> only 11-30 steps possible
 0 <input type="checkbox"/> only 1-10 steps possible</p> | <p>3. Squatting / kneeling
 <i>check one box:</i>
 40 <input type="checkbox"/> normal, unlimited
 30 <input type="checkbox"/> some limitations
 20 <input type="checkbox"/> only 6-10 possible
 0 <input type="checkbox"/> only 0-5 possible</p> |
|--|---|---|

Level _____ / 3= _____

Function Sports

Check the problems you have during:

- | | | |
|--|---|---|
| <p>1. Straight running
 <i>check one box:</i>
 100 <input type="checkbox"/> fully competitive
 80 <input type="checkbox"/> some limitations, guarding
 60 <input type="checkbox"/> definite limitations, half speed
 40 <input type="checkbox"/> not able to do</p> | <p>2. Jumping / landing on affected leg
 <i>check one box:</i>
 100 <input type="checkbox"/> fully competitive
 80 <input type="checkbox"/> some limitations, guarding
 60 <input type="checkbox"/> definite limitations, half speed
 40 <input type="checkbox"/> not able to do</p> | <p>3. Hard twists / cuts / pivots
 <i>check one box:</i>
 100 <input type="checkbox"/> fully competitive
 80 <input type="checkbox"/> some limitations, guarding
 60 <input type="checkbox"/> definite limitations, half speed
 40 <input type="checkbox"/> not able to do</p> |
|--|---|---|

Level _____ / 3= _____

Problems with Sports

Describe the problems you would have with your knee after participating for one hour without guarding or limitations in each of the three sports categories below. (_____ check here if you are using a brace.)

- | | | |
|---|--|---|
| <p>Strenuous Sport
 (soccer, football, basketball, volleyball)
 <i>check one box:</i>
 100 <input type="checkbox"/> no problems
 <input type="checkbox"/> moderate problems during or after game
 <input type="checkbox"/> severe problems; cannot participate</p> | <p>Moderate Sport
 (tennis, racquetball)
 <i>check one box:</i>
 80 <input type="checkbox"/> no problems
 <input type="checkbox"/> moderate problems during or after game
 <input type="checkbox"/> severe problems; cannot participate</p> | <p>Light Sport
 (golf, bowling, hiking)
 <i>check one box:</i>
 60 <input type="checkbox"/> no problems
 50 <input type="checkbox"/> moderate problems during or after game
 30 <input type="checkbox"/> severe problems; cannot participate</p> |
|---|--|---|

Total Points _____