

The Knee Injury and Osteoarthritis Outcome Score

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: Please mark the box that best represents your experience attributable to your knee problem.

Pain

P1	How often is your knee painful?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
What degree of pain have you experienced the last week when...?						
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 surfaces	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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

Symptoms

Sy1	How severe is your knee 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
Sy2	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
Sy3	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
Sy4	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
Sy5	Does your knee catch or hand up when moving?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Sy6	Can you straighten your knee fully?	<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Sy7	Can you bend your knee fully?	<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never

Activities of Daily Living

What difficulty have you experienced last week...?						
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
A3	Raising 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

Turn the page

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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
A16	Heavy domestic duties (shoveling, scrubbing floors, etc.)	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A17	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

Sport and Recreation Function

What difficulty have you experienced last week...?

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	Turning/twisting on your injured knee	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sp5	Kneeling	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

Knee-related Quality of Life

What difficulty have you experienced last week...?

Q1	How often are you aware of your knee problems?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
Q2	Have you modified your lifestyle to avoid potentially damaging activities to your knee?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
Q3	How troubled are you with lack of confidence in your knee?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
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

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

Source: Koos et al. (1998). JOSPT 78, 88-96

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