Bay Area Neuromuscular-Therapy & Regenerative Medicine

PATIENT NAME: _____

DOB: _____/_____/_____

TODAY'S DATE: _____/_____/_____

PRACTITIONER

☐ _____

☐ Heather Simmons, ARNP

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

Answer every question by ticking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms - These questions should be answered thinking of your knee symptoms during the **last week.**

S1. Do you have swelling in your knee?

◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

S3. Does your knee catch or hang up when moving?

◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

S4. Can you straighten your knee fully?

◯ Always ◯ Often ◯ Sometimes ◯ Rarely ◯ Never

S5. Can you bend your knee fully ?

◯ Always ◯ Often ◯ Sometimes ◯ Rarely ◯ Never

Stiffness - The following 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.

S6. How severe is your knee joint stiffness after first wakening in the morning?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

S7. How severe is your knee stiffness after sitting, lying or resting **later in the day?**

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

Subtotal:

Pain

P1. How often do you experience knee pain?

◯ Never ◯ Monthly ◯ Weekly ◯ Daily ◯ Always

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

P3. Straightening knee fully

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

P4. Bending knee fully

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

P5. Walking on flat surface

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

P6. Going up or down stairs

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

P7. At night while in bed

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

P8. Sitting or lying

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

P9. Standing upright

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Subtotal:

Function, daily living - The following questions concern your physical function. By this we mean your ability to move around and to 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.

AI. Descending stairs

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A2. Ascending stairs

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A3. Rising from sitting

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A4. Standing

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A5. Bending to floor/pick up an object

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A6. Walking on flat surface

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A7. Getting in/out of car

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A8. Going shopping

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A9. Putting on socks/stockings

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A10. Rising from bed

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A11. Taking off socks/stockings

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A12. Lying in bed (turning over, maintaining knee position)

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A13. Getting in/out of bath

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A14. Sitting

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A15. Getting on/off toilet

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A17. Light domestic duties (cooking, dusting, etc)

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Subtotal:

Function, sports and recreational activities - 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.

SP1. Squatting

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP2. Running

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP3. Jumping

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP4. Twisting/pivoting on your injured knee

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP5. Kneeling

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Subtotal:

Quality of Life

Q1. How often are you aware of your knee problem?

○ Never ○ Monthly ○ Weekly ○ Daily ○ Constantly

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

○ Not at all ○ Mildly ○ Moderately ○ Severely ○ Totally

Q3. How much are you troubled with lack of confidence in your knee?

○ Not at all ○ Mildly ○ Moderately ○ Severely ○ Extremely

Q4. In general, how much difficulty do you have with your knee?

○ None ○ Mild ○ Moderately ○ Severe ○ Extreme

Subtotal:

Thank you very much for completing all the questions in this questionnaire.

Will be scored by the BAN practitioner.

Knee Injury & Osteoarthritis Outcome Score is

Reference for Score: Roos EM, Roos HP, Lohmander LS, Ekdahl C, Beynnon BD. Knee Injury and Osteoarthritis Outcome Score (KOOS)--development of a self-administered outcome measure. J Orthop Sports Phys Ther. 1998 Aug;28(2):88-96. **Link**

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