

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

<b>Pain</b>	<b>Location of pain</b>	<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
	<b>Type of pain</b>	<input type="checkbox"/> sharp	<input type="checkbox"/> aching	<input type="checkbox"/> throbbing	<input type="checkbox"/> burning	
	<b>Pain occurs on</b>	<input type="checkbox"/> sitting	<input type="checkbox"/> standing	<input type="checkbox"/> stairs	<input type="checkbox"/> squatting	<input type="checkbox"/> running / jumping
	<b>Pain relieved</b>	<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	3	4	5	6	7	8	9	10
	poor		fair		good				normal

**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 = \_\_\_\_\_ = \_\_\_\_\_

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