Name: _____ Date:_____

Score:_____

Knee Outcome Survey – ADL Scale

Over the LAST 1 to 2 DAYS, check the one statement that best describes you.

Symptoms: To what degree does each of the following symptoms ***affect your level of daily activity***?

	I Do Not Have the 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 Activities
1. **Pain**	☐	☐	☐	☐	☐	☐
2. **Stiffness**	☐	☐	☐	☐	☐	☐
3. **Swelling**	☐	☐	☐	☐	☐	☐
4. **Giving Way, Buckling or Shifting of Knee**	☐	☐	☐	☐	☐	☐
5. **Weakness**	☐	☐	☐	☐	☐	☐
6. **Limping**	☐	☐	☐	☐	☐	☐
	5	4	3	2	1	0

Functional Limitations with Activities of Daily Living: How does your knee affect your ability to...

The Activity Is…	Not Difficult	Minimally Difficult	Somewhat Difficult	Fairly Difficult	Very Difficult	I am Unable to Do the Activity
1. Walk?	☐	☐	☐	☐	☐	☐
2. Go up stairs?	☐	☐	☐	☐	☐	☐
3. Go down stairs?	☐	☐	☐	☐	☐	☐
4. Stand?	☐	☐	☐	☐	☐	☐
5. Kneel on the front of your knee?	☐	☐	☐	☐	☐	☐
6. Squat?	☐	☐	☐	☐	☐	☐
7. Sit with your knee bent?	☐	☐	☐	☐	☐	☐
8. Rise from a chair?	☐	☐	☐	☐	☐	☐
	5	4	3	2	1	0

Please rate your level of pain in the last 24 hours on the following scale. (Choose One)

No **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Severe**

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