ATHLETIC KNEE QUESTIONAIRE

Name: _____Date: _____
Age: _____Knee: L/R Duration of symptoms: _____ years _____ months
For each question, circle the latest choice (letter), which corresponds to your knee symptoms.

1. Limp
(a) None (5)
(b) Slight or periodical (3)
(c) Constant (0)

2. Support
(a) Full support without pain (5)
(b) Painful (3)
(c) Weight bearing impossible (0)

3. Walking
(a) Unlimited (5)
(b) More than 2 km (3)
(c) 1-2 km (2)
(d) Unable (0)

4. Stairs
(a) No difficulty (10)
(b) Slight pain when descending (8)
(c) Pain both when descending and ascending(5)
(d) Unable (0)

5. Squatting
(a) No difficulty (5)
(b) Repeated squatting painful (4)
(c) Painful each time (3)
(d) Possible w/ partial weight bearing(2)
(e) Unable (0)

6. Running
(a) No difficulty (10
(b) Pain after more than 2 km (8)
(c) Slight pain from start (6)
(d) Severe pain (3)
(e) Unable (0)

7. Jumping
(a) No difficulty (10)
(b) Slight difficulty (7)
(c) Constant pain (2) (d) Unable (0)

8. Prolonged sitting with knees flexed
(a) No difficulty (10)
(b) Pain after exercise (8)
(c) Constant pain (6)
(d) Pain forces to extend knees temporarily (4)
(e) Unable (0)

9. Pain
(a) None (10)
(b) Slight and occasional (8)
(c) Interferes with sleep (6)
(d) Occasionally severe (3)
(e) Constant and severe (0)

10. Swelling
(a) None (10)
(b) After severe exertion (8)
(c) After daily activities (6)
(d) Every evening (4)
(e) Constant (0)

11. Abnormal painful kneecap (patellar)movements (subluxations)
(a) None (10)
(b) Occasionally in sports activities (6)
(c) Occasionally in daily activities (4)
(d) At least 1 documented dislocation(2)
(e) More than 2 dislocations(0)

12. Atrophy of thigh
(a) None (5)
(b) Slight (3)
(c) Severe (0)

13. Flexion deficiency
(a) None (5)
(b) Slight (3)
(c) Severe (0)

Reference: Kujala UM, Jaakkola LH, Koskinen SK, Taimela S, Hurme M, Nelimarkka O: **Scoring of patellofemoral disorders.** *Arthroscopy* 1993, **9:**159-163.

THE LOWER EXTREMITY FUNCTIONAL SCALE

This questionnaire has been designed to give the doctor/physical therapist information as to how your lower limb has affected your ability to manage in daily life. Please answer every question by circling the number below the appropriate response. Please only mark ONE response per question.

	Today, do you or would you have any difficulty at all with:	EXTREME DIFFICULTY OR UNABLE TO PERFORM	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of the car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking 1 mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4

To be completed by physical therapist/provider only SCORE: _____/80