THE STONE CLINIC | NEW KNEE INJURY QUESTIONNAIRE

Your Full Name: _____ Today's Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Injury: ☐ Right ☐ Left Date of Injury: _____ / _____ / _____

SYMPTOMS*:
**Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activities at this level.*

1. What is the highest level of activity that you can perform without significant knee pain?

   ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
   ☐ Strenuous activities like heavy physical work, skiing or tennis
   ☐ Moderate activities like moderate physical work, running or jogging
   ☐ Light activities like walking, housework or yard work
   ☐ Unable to perform any of the above activities due to knee pain

2. During the past 4 weeks, or since your injury, how often have you had pain?

	0	1	2	3	4	5	6	7	8	9	10	
Never	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	*Constant*

3. If you have pain, how severe is it?

	0	1	2	3	4	5	6	7	8	9	10	
No pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	*Worst pain Imaginable*

4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

   ☐ Not at all
   ☐ Mildly
   ☐ Moderately
   ☐ Very
   ☐ Extremely

5. What is the highest level of activity you can perform without significant swelling in your knee?

   ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
   ☐ Strenuous activities like heavy physical work, skiing or tennis
   ☐ Moderate activities like moderate physical work, running or jogging
   ☐ Light activities like walking, housework, or yard work
   ☐ Unable to perform any of the above activities due to knee swelling

6. During the past 4 weeks, or since your injury, did your knee lock or catch?

   ☐ Yes ☐ No

7. What is the highest level of activity you can perform without significant giving way in your knee?

   ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
   ☐ Strenuous activities like heavy physical work, skiing or tennis
   ☐ Moderate activities like moderate physical work, running or jogging
   ☐ Light activities like walking, housework or yard work
   ☐ Unable to perform any of the above activities due to giving way of the knee

SPORTS ACTIVITIES:

8. What is the highest level of activity you can participate in on a regular basis?

☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
☐ Strenuous activities like heavy physical work, skiing or tennis
☐ Moderate activities like moderate physical work, running or jogging
☐ Light activities like walking, housework or yard work
☐ Unable to perform any of the above activities due to knee

9. How does your knee affect your ability to:

		Not difficult at all	Minimally difficult	Moderately Difficult	Extremely difficult	Unable to do
a.	Go up stairs	☐	☐	☐	☐	☐
b.	Go down stairs	☐	☐	☐	☐	☐
c.	Kneel on the front of your knee	☐	☐	☐	☐	☐
d.	Squat	☐	☐	☐	☐	☐
e.	Sit with your knee bent	☐	☐	☐	☐	☐
f.	Rise from a chair	☐	☐	☐	☐	☐
g.	Run straight ahead	☐	☐	☐	☐	☐
h.	Jump and land on your involved leg	☐	☐	☐	☐	☐
i.	Stop and start quickly	☐	☐	☐	☐	☐

FUNCTION:

10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities?

FUNCTION PRIOR TO YOUR KNEE INJURY:

Cannot perform daily activities	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	*No Limitation*

CURRENT FUNCTION OF YOUR KNEE:

Cannot perform daily activities	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	*No Limitation*

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 fully straighten your knee fully?	☐ **Always**	☐ **Often**	☐ **Sometimes**	☐ **Rarely**	☐ **Never**
S5	Can you bend your knee fully?	☐ **Always**	☐ **Often**	☐ **Sometimes**	☐ **Rarely**	☐ **Never**
S6	How severe is your knee stiffness after first waking 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**

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**

ACTIVITIES OF DAILY LIVING

What difficulty have you experienced in the last week…?

A1	Descending stairs	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A2	Ascending stairs	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A3	Rising from sitting	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A4	Standing	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A5	Bending to floor / picking up an object	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A6	Walking on a flat surface	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A7	Getting in/out of a 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 the bath	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A14	Sitting	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A15	Getting on/off the toilet	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A16	Heavy domestic duties (shoveling, scrubbing floors, etc)	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
A17	Light domestic duties (cooking, dusting, etc)	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**

SPORTS AND RECREATION FUNCTION

What difficulty have you experienced in the last week…?

SP1	Squatting	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
SP2	Running	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
SP3	Jumping	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
SP4	Turning/twisting on your injured knee	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**
SP5	Kneeling	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**

KNEE RELATED QUALITY OF LIFE

Q1	How often are you aware of your knee problems?	☐**Never**	☐**Monthly**	☐**Weekly**	☐**Daily**	☐**Always**
Q2	Have you modified your lifestyle to avoid potentially damaging activities to your knee?	☐**Not at all**	☐**Mildly**	☐**Moderately**	☐**Severely**	☐**Totally**
Q3	How troubled are you with lack of confidence in your knee?	☐**Not at all**	☐**Mildly**	☐**Moderately**	☐**Severely**	☐**Totally**
Q4	In general, how much difficulty do you have with your knee?	☐**None**	☐**Mild**	☐**Moderate**	☐**Severe**	☐**Extreme**

Please indicate in the spaces below the HIGHEST level of activity that you participated in BEFORE YOUR INJURY and the highest level you are able to participate in CURRENTLY.

Level 10	**Competitive sports** soccer, football, rugby (national elite)
Level 9	**Competitive sports** soccer, football, rugby **(lower divisions)** ice hockey, wrestling, gymnastics, basketball
Level 8	**Competitive sports** racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing
Level 7	**Competitive sports** tennis, running, motorcars speedway, handball **Recreational sports** soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running
Level 6	**Recreational sports** tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week
Level 5	**Work** heavy labor (construction, etc.) **Competitive sports** cycling, cross-country skiing **Recreational sports** jogging on uneven ground at least twice weekly
Level 4	**Work** moderately heavy labor (e.g. truck driving, etc.)
Level 3	**Work** light labor (nursing, etc.)
Level 2	**Work** light labor **Walking on uneven ground possible, but impossible to back pack or hike**
Level 1	**Work** sedentary (secretarial, etc.)
Level 0	**Sick leave** or **disability pension** because of knee problems

BEFORE INJURY: Level _____ **CURRENT: Level _____**

1. How satisfied are you with your medical care? Please place **ONLY ONE** "X" on the line below.

Least Satisfied	0	100	*Most Satisfied*

2. How normal does your affected joint feel? Please place **ONLY ONE** "X" on the line below.

Least Normal	0	100	*Normal*

3. How would you rate your pain? Please place **ONLY ONE** "X" on the line below.

No pain	0	100	*Worst pain Imaginable*

1) In general, would you say your health is:

☐ 1. Excellent

☐ 2. Very Good

☐ 3. Good

☐ 4. Fair

☐ 5. Poor

2) The following questions are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐1	☐2	☐3
Climbing several flights of stairs	☐1	☐2	☐3

3) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
Accomplished less than you would like	☐1	☐2	☐3	☐4	☐5
Were limited in the kind of work or other activities	☐1	☐2	☐3	☐4	☐5

4) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
Accomplished less than you would like	☐1	☐2	☐3	☐4	☐5
Didn't do work or other activities as carefully as usual	☐1	☐2	☐3	☐4	☐5

5) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐1. Not at All

☐2. A Little Bit

☐3. Moderately

☐4. Quite a Bit

☐5. Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks.
For each question, please give the one answer that comes closest to the way you have been feeling.

6) How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

Now, we'd like to ask you some questions about how your health may have changed.

7) During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐1. All of the time
☐2. Most of the time
☐3. Some of the time
☐4. A little of the time
☐5. None of the time

8) Compared to one year ago, how would you rate your physical health in general now?

☐1. Much better
☐2. Slightly better
☐3. About the same
☐4. Slightly worse
☐5. Much worse

9) Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) now?

☐1. Much better
☐2. Slightly better
☐3. About the same
☐4. Slightly worse
☐5. Much worse

Please indicate how often you performed each activity in your healthiest and most active state, in the past year. On each of the four rows, please place a ☑ in the appropriate column.

	Less than once a month	Once a month	Once a week	2 – 3 times a week	4+ times a week
Running running while playing a sport or jogging					
Cutting Changing directions while running					
Decelerating Coming to a quick stop while running					
Pivoting Turning your body with your foot planted while playing sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.					