



<b>Knee Functional Assessment</b>	<i>( Please mark only 1 box for each area)</i>		
	Affected Knee:	<input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Both
I stay home most of the time because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
When I sit, I change positions frequently to get my knee comfortable.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I walk slower than normal because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee I am not doing any of the jobs that I usually do around the house.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee I use handrails on stairs.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee I lie down and rest more often.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee I have difficulty driving.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I get dressed slower than normal because of my knee pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee pain I try and get other people to do things for me.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I only stand for short periods of time because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I find it difficult to get out of a chair because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee pain I cannot squat down.	<input type="checkbox"/> True	<input type="checkbox"/> False	
My knee is painful almost all the time.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Running is difficult because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
My appetite is not good because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I have trouble putting my shoes and socks on because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I walk only short distances because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I don't sleep as well because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I have difficulty going up stairs because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I have difficulty going down stairs because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I sit down for most of the day because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee it takes me longer to get going in the morning.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my knee pain I am more irritable and bad tempered with people than usual.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I need to take medication for my knee pain in order to complete daily activities.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I need to modify my fitness activities because of my knee.	<input type="checkbox"/> True	<input type="checkbox"/> False	
_____ / 25 Functional Restrictions			

Name: \_\_\_\_\_

Date: \_\_\_\_\_



TOEPPERWEIN  
**PHYSICAL THERAPY**™  
*& Spine Rehab*

( Please mark only 1 box for each area)

<b>Lower Extremity Functional Scale</b>	Extreme Difficulty	Quite a Bit Difficulty	Moderate Difficulty	A little Bit of Difficulty	No Difficulty
Any of your usual work, housework, or school activities.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Your usual hobbies, recreational or sporting activities.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Getting into or out of the bath.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Walking between rooms.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Putting on your shoes or socks.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Squatting.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lifting an object, like a bag of groceries from the floor.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Performing light activities around your home.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Performing heavy activities around your home.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Getting into or out of a car.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Walking 2 blocks.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Walking a mile.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Going up or down 10 stairs (about 1 flight of stairs).	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Standing for 1 hour.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Sitting for 1 hour.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Running on even ground.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Running on uneven ground.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Making sharp turns while running fast.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Hopping.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Rolling over in bed.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Column Totals:	_____	_____	_____	_____	_____
Minimum Level of Detectable Change (90% Confidence): 9 points	SCORE: _____ / 80				

Name: \_\_\_\_\_

Date: \_\_\_\_\_