

KOOS-Physical Function Shortform (KOOS-PS)

Today's date: _____ / _____ / _____ Date of birth: _____ / _____ / _____

Name: _____

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how well you are able to perform different activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can so that you answer all the questions.

The following questions concern your level of function in performing usual daily activities and higher level activities. For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee problem.

1. Rising from bed

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Putting on socks/stockings

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Rising from sitting

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Bending to floor

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. Twisting/pivoting on your injured knee

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. Kneeling

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. Squatting

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |