

Study ID: _____

Pre-op, 3 mo, 6 mo, 1 yr, 2 yr, 3 yr,
5 yr, 10 yr, 15 yr, 20 yr, 25 yr, 30 yr

Appendix C:
Title:
West Point Knee Evaluation Form

Today's Date: _____

Year of Graduation: _____

A. INJURY HISTORY

1. Date of Initial Injury: _____

2. What type of sport you were playing when you were injured?

- a. Contact Sport
- b. Contact Sport
- c. Non Contact Sport
- d. Other _____

3. What sport were you playing when you were injured? If no sport involved, please explain the activity.

4. Please circle the type of injury you sustained and explain the circumstances surrounding your injury.

- a. Contact injury _____
- b. Non-contact injury _____
- c. Other _____

5. When you were injured, at what level of competition were you playing?

- a. Corps Squad Athletics
- b. Club
- c. IM
- d. Department of Physical Education
- e. Free-time activity
- f. Military Training activity

6. What is your dominant leg (the one you kick with)?

- a. right
- b. left

7. What knee did you injure?

- a. right
- b. left

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8. **At what speed can you run 2 miles right now? If you are unable to run, please state that you are unable to run.**

9. **At what speed could you run 2 miles before your knee injury?**

10. **What sports have you played since your injury? (Please list them all)**

11. **At what level are you currently functioning?**

- a. At Pre-Injury level
- b. Better Than Pre-Injury Level

12. **At what percent of your pre-injury level are you functioning?**

_____ % of Pre-Injury Level

13. **How many hours per week do you participate in sports/activities?**

_____ hrs / wk

14. **On a scale from 1 – 100, how would you rate your knee with 100 being normal?**

B. POST-OPERATIVE EVALUATION

Please indicate N/A if you have either not yet had surgery or elected not to have surgery.

1. **Date of surgery:** _____

2. **Please list all previous surgeries you have had, the date, and the type of procedure.**

3. **Where did you spend the majority of time rehabilitating your shoulder during the following periods (e.g. Physical Therapy, DPE training room)**

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a. Day of Surgery thru 4 Weeks Post-op: _____

b. 1 Month Post-op thru 3 Months Post-op: _____

c. 4 Months Post-op thru 6 Months Post-op: _____

4. Which courses have you had since surgery (circle all that apply and indicate any additional courses)?

- a. boxing
- b. wrestling
- c. CQC
- d. Military Movements – Gymnastics
- e. swimming
- f. IOCT
- g. Other _____

5. Since surgery, have you had any of the following:

Recurrent Swelling? Yes No

If yes, with which activities? _____

Recurrent Episodes of “Giving Way” Yes No

If yes, during which activities? _____

Recurrent Pain? Yes No

If yes, during which activities? _____

COMMENTS: *(Please feel free to provide us with feedback on your care and current status)*

C. HEALTH STATUS QUESTIONNAIRE (SF-36)

This survey asks for your views about your general health. Please answer every question by circling the appropriate number. If you are unsure about how to answer a question, please give it the best answer you can and make a comment in the left margin, or on the back.

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

- Excellent 1
- Very good 2
- Good 3
- Fair 4
- Poor 5

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than 1 year ago 1
- Somewhat better now than 1 year ago 2
- About the same 3
- Somewhat worse now than 1 year ago 4
- Much worse now than 1 year ago 5

3. 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
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than 1 mile	1	2	3
h. Walking several hundred yards	1	2	3
i. Walking one hundred yards	1	2	3
j. Bathing and dressing yourself	1	2	3

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

	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a. Cut down on the amount of time you spent on work or other activities	1	2	3	4	5
b. Accomplished less than you would like	1	2	3	4	5
c. Were limited in the kind of work or other activities	1	2	3	4	5
d. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2	3	4	5

5. 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)?

	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a. Cut down on the amount of time you spent on work or other activities	1	2	3	4	5
b. Accomplished less than you would like	1	2	3	4	5
c. Didn't do work or other activities as carefully as usual	1	2	3	4	5

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6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all 1
- Slightly 2
- Moderately 3
- Quite a bit 4
- Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

- None 1
- Very mild 2
- Mild 3
- Moderate 4
- Severe 5
- Very severe 6

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

- Not at all 1
- A little 2
- Moderately 3
- Quite a bit 4
- Extremely 5

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

	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	1	2	3	4	5
b. Have you been very nervous?	1	2	3	4	5
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5
d. Have you felt calm and peaceful?	1	2	3	4	5
e. Did you have a lot of energy?	1	2	3	4	5
f. Have you felt downhearted and depressed?	1	2	3	4	5
g. Did you feel worn out?	1	2	3	4	5
h. Have you been a happy person?	1	2	3	4	5
i. Did you feel tired?	1	2	3	4	5

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

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

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

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D. LYSHOLM KNEE SCORE

Please circle the letter of the response that best describes the function of your knee at this time.

1. How much do you notice yourself limping?

- A. None
- B. Slight or periodic
- C. Severe or constant

2. Do you require crutch support?

- A. None
- b. Cane or crutch
- c. Weight bearing impossible

3. Does your knee lock-up on you (locking is when you knee gets stuck in a bent position and you cannot straighten it without moving it around)?

- A. No locking or catching sensations
- b. Catching sensation but no locking
- c. Locking occasionally
- d. Locking frequently
- e. Locked now

4. Describe you knee function with stairclimbing:

- A. No problems
- b. Slightly impaired
- c. One step at a time
- d. Impossible

5. Describe your knee function with squatting:

- A. No problems
- b. Slightly impaired
- c. Not beyond 90 degrees
- d. Impossible

6. Describe any knee instability you have:

- A. Never gives way
- b. Rarely gives way during athletics or other severe exertion
- c. Frequently gives way during athletics or other severe exertion or incapable of participation
- d. Occasionally gives way in daily activities
- e. Often gives way in daily activities
- f. Givers way with every step

7. How much pain do you have?

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- A. None
- b. Inconstant and slight during severe exertion
- c. Marked during severe exertion
- d. Marked on or after walking more than 2 km
- e. Marked on or after walking less than 2 km
- f. Constant

8. How much do you notice your knee swelling?

- a. none
- b. on severe exertion
- c. on ordinary exertion
- d. constant

9. How does your knee function?

- A. Normal
- b. Nearly normal
- c. Abnormal
- d. Severely abnormal

10. How does your knee affect your activity level?

- A. Does not interfere with any activity you choose to participate in
- B. Interferes only slightly
- C. Interferes moderately
- d. Interferes a great deal

E. KOOS

Please answer each question by checking the appropriate box, only one box for each question.

1. 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 |
| <input type="checkbox"/> |

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never | Rarely | Sometimes | Often | Always |
| <input type="checkbox"/> |

S3. Does your knee catch or hang up when moving?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never | Rarely | Sometimes | Often | Always |
| <input type="checkbox"/> |

S4. Can you straighten your knee fully?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Always | Often | Sometimes | Rarely | Never |
| <input type="checkbox"/> |

S5. Can you bend your knee fully?

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Always

Often

Sometimes

Rarely

Never

2. Stiffness

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

S6. How severe is your joint stiffness after first wakening in the morning?

None

Mild

Moderate

Severe

Extreme

S7. How severe is your stiffness after sitting, lying or resting **later in the day**?

None

Mild

Moderate

Severe

Extreme

3. 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

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4. Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs

None Mild Moderate Severe Extreme

A2. Ascending stairs

None Mild Moderate Severe Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A3. Rising from sitting

None Mild Moderate Severe Extreme

A4. Standing

None Mild Moderate Severe Extreme

A5. Bending to floor/pick up and object

None Mild Moderate Severe Extreme

A6. Walking on flat surface

None Mild Moderate Severe Extreme

A7. Getting in/out of 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)

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

A13. Getting in/out of bath

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

A14. Sitting

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

A15. Getting on/off toilet

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

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A16. Heavy domestic duties (shoveling snow, scrubbing floors etc)

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

A17. Light domestic duties (cooking, dusting etc)

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

5. Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting

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

SP2. Running

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

SP3. Jumping

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

SP4. Twisting/pivoting on your injured knee

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

SP5. Kneeling

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

6. Quality of Life

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Q1. How often are you aware of your knee problem?

Never

Monthly

Weekly

Daily

Constantly

Q2. Have you modified your lifestyle to avoid potentially damaging activities to your knee?

Not at all

Mildly

Moderately

Severely

Totally

Q3. How much are you troubled 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

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F. TEGNER ACTIVITY SCORE

Please circle the number which best corresponds to your current activity level. Circle only one number. Put an X next to the number that corresponds to your pre-injury activity level.

10. Competitive sports
Elite athlete
9. Competitive sports
Soccer, lower divisions
Ice hockey, Wrestling, Gymnastics, football
8. Competitive sports
Bandy, Squash or badminton
Athletics (jumping, etc.)
Downhill skiing
7. Competitive sports
Tennis, Handball
Athletics (running)
Motorcross, speedway
Basketball
Recreational sports
Soccer, Squash
Bandy and ice hockey
Athletics (jumping)
Cross-country track findings both recreational and competitive
6. Recreational sports
Tennis and badminton
Handball
Basketball
Downhill skiing
Jogging, at least five times per week
5. Work – heavy labor (e.g., building, forestry)
Competitive sports
Cycling
Cross-country skiing
Recreational sports
Jogging on uneven ground at least twice weekly
4. Work – Moderately heavy labor (e.g., truck driving, heavy domestic work)
Recreational sports
Cycling
Cross-country skiing
Jogging on even ground at least twice weekly
3. Work – Light labor (e.g., nursing)
Competitive and recreational sports - swimming
2. Work – Light labor
Walking on uneven ground possible but impossible to walk in forest
1. Work – Sedentary work
Walking on even ground possible
0. Sick leave or disability pension because of shoulder problems

G. 2000 IKDC Subjective Knee Evaluation Form

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	<input type="checkbox"/>	Constant										

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

	0	1	2	3	4	5	6	7	8	9	10	
No pain	<input type="checkbox"/>	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

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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	<input type="checkbox"/>				
b.	Go down stairs	<input type="checkbox"/>				
c.	Kneel on the front of your knee	<input type="checkbox"/>				
d.	Squat	<input type="checkbox"/>				
e.	Sit with your knee bent	<input type="checkbox"/>				
f.	Rise from a chair	<input type="checkbox"/>				
g.	Run straight ahead	<input type="checkbox"/>				
h.	Jump and land on your involved leg	<input type="checkbox"/>				
i.	Stop and start quickly	<input type="checkbox"/>				

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 which may include sports?

FUNCTION PRIOR TO YOUR KNEE INJURY:

Cannot perform daily activities 0 1 2 3 4 5 6 7 8 9 10 No limitation in daily activities

CURRENT FUNCTION OF YOUR KNEE:

Cannot perform daily activities 0 1 2 3 4 5 6 7 8 9 10 No limitation in daily activities