# IKDC DEMOGRAPHIC FORM

Your Full Name							
Your Date of Birth		Month	/	Year			
Your Social Security Nun	nber _	<del>-</del>		Yo	ur Gende	er: 🗖 Ma	ale 🗖 Female
Occupation							
Today's Date	/	Month	/	Year			
The following is a list of comm to the next item. If you do hasome other type of treatment activities.	ave the for the	problem, p problem.	olease ind In the	icate in th last colun	ne second ( nn, indicat	column if yo e if the pr	ou receive medications o
	Do you the pro		Do you treatme	receive nt for it?	Does it your a	timit ctivities?	
	Yes	No	Yes	No	Yes	No	
Heart disease							
High blood pressure							
Asthma or pulmonary disease							
Diabetes							
Ulcer or stomach disease							
Bowel disease							
Kidney disease							
Liver disease							
Anemia or other blood disease							
Overweight							
Cancer							
Depression							
Osteoarthritis, degenerative arthritis							
Rheumatoid arthritis							
Back pain							
Lyme disease							
Other medical problem							
Alcoholism							

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1.	Do you smoke cigarettes?										
	☐ Yes☐ No, I quit in the last six months.☐ No, I quit more than six months ago.☐ No, I have never smoked.										
2.	Your height										
3.	Your weight										
4.	Your race (indicate all that apply)										
	☐White ☐Black or African-American ☐Hispanic										
	☐ Asian or Pacific Islander ☐ Native American Indian ☐ Other										
5.	How much school have you completed?										
	☐ Less than high school ☐ Graduated from high school ☐ Some college										
	☐Graduated from college ☐Postgraduate school or degree										
6.	Activity level										
	☐ Are you a high competitive sports person?										
	☐ Are you well-trained and frequently sporting?										
	☐Sporting sometimes										
	□Non-sporting										

## IKDC CURRENT HEALTH ASSESSMENT FORM \*

Yo	ur Ful	I Name								-	
Yo	ur Dat	e of Birth		/_		/					
			Day		Month	1	Year				
То	day′s I	Date	Day	/	Month	/_ n	Year				
1.	In ger	neral, would y	you say yo	our hea	Ith is: $\square$	<b>I</b> Excellent	: □Very God	od 🖵 Goo	od <b>□</b> Fair	Poor	r
2.	Comp	ared to one v	ear ann	how we	uld vou	rate voui	r health in gene	eral now?			
۷.		-	· ·		_	J	· ·				4
	<b>□</b> IVIU0	ch better now	tnan i y	ear ago	) <b>U</b> S0	omewnat	better now than	n i year ago	<b>□</b> About	tne same	as 1 year ago
	□Son	newhat worse	e now tha	n 1 yea	ır ago	■Much	worse now that	an 1 year ago	)		
3.		•			ties you	might do	during a typica	al day. Does	your health	now limit	you in
	these	activities? If	so, how i	much?				Yes,	Yes,	No, Not	
								Limited A Lot	Limited A Little	Limited At All	
	a.	Vigorous ac			_	lifting he	eavy objects,				
	b.	Moderate advacuum clea			_		oushing a				
	C.	Lifting or ca	arrying gro	oceries							
	d.	Climbing se	veral fligh	its of st	airs						
	e.	Climbing on	ne flight of	stairs							
	f.	Bending, kn	neeling or	stoopin	ıg						
	g.	Walking mo	re than a	mile							
	h.	Walking sev	eral block	(S							
	i.	Walking one	e block								
	j.	Bathing or o	dressing y	ourself							
4.		g the <u>past 4 v</u> ies as a resul		,	,		ollowing problem	ns with your		Ü	daily
		0	41		41				YES		
	a.				,	•	n work or other	activities			
	b.	Accomplishe									
	C.	Were limited									
	d.	extra effort)		ning the	e work o	r other a	ctivities (for exa	ample, it took			
5.							ollowing problem n as feeling dep			er regular (	daily
									YES	NO	
	a.	Cut down o	n the amo	ount of	time you	u spent o	n work or other	activities			
	b.	Accomplishe	ed less th	nan you	would li	ike					
	C.	Didn't do w	ork or oth	er activ	ities as	carefully	as usual				

### Page 2 – IKDC CURRENT HEALTH ASSESSMENT FORM \*

6.	• .	<u>1 weeks,</u> to what ex ivities with family, f	-			or emotion	nal problei	ms interfere	ed with your
	□Not At All	Slightly	■Moder	ately	<b>□</b> Quite a	Bit	□Extren	nely	
7.	How much bodily	, pain have you had	I during the	past 4 v	veeks?				
	□None	□Very Mild	□Mild		□ Modera	te	□Sever	e 🗖\	Very Severe
8.	During the past 4 home and house	1 weeks, how much work)?	did pain in	terfere w	vith your n	ormal wor	k (includir	ng both wo	rk outside the
	□Not at All	☐A Little Bit	□Moder	ately	☐Quite a	Bit	□Extrer	nely	
9.	For each question	are about how you n, please give the c e time during the <u>pa</u>	ne answer	that com			•	•	
				All of the time	Most of the time	A good bit of the time	Some of the time		None of the time
	a. Did you feel	full of pep?							
	b. Have you be	en very nervous?							
	c. Have you fel	t calm and peacefu	l?						
	d. Did you have	e a lot of energy?							
	5	It down-hearted and	d blue?						
	f. Did you feel								
	9	een a happy person							
	h. Did you feel	tirea?							
10.		<u>1 weeks,</u> how much ties (like visiting wi				health or	emotional	problems i	interfered with
	☐All of the time	☐Most of the tin	ne 🔲 Som	e of the	time $\Box$	A little of t	he time	☐ None of	the time
11.	How TRUE or FA	LSE is each of the f	following sta	atements	for you?				
					Defin Tru	ie Tr	stly Do ue Kno	ow False	False
		get sick a little easi		er people					
	b. I am as he	ealthy as anybody I	know			1 [		1 🗆	
	c. I expect m	y health to get wor	rse			1 [		ı 🗆	
	d. My health	is excellent				1 [		<b>1</b>	

<sup>\*</sup>This form includes questions from the SF-36™ Health Survey. Reproduced with the permission of the Medical Outcomes Trust, Copyright © 1992.

# 2000 IKDC SUBJECTIVE KNEE EVALUATION FORM

Υοι	ır Fu	ıll Nam	e										
Too	lay's	Date: _	Day	/	_/ Year			Date	of Injury	y: Day	/ Month	/_ n Yea	ar
*Gr	ade		ms at t				at whic		nink you	could fu	unction v	vithout s	ignificant symptoms,
1.	Wha	at is the	highes	st level o	of activit	y that y	ou can p	perform	without	significar	nt knee į	oain?	
		<sup>4</sup> Very strenuous activities like jumping or pivoting as in basketball or soccer <sup>3</sup> Strenuous activities like heavy physical work, skiing or tennis <sup>2</sup> Moderate activities like moderate physical work, running or jogging <sup>1</sup> Light activities like walking, housework or yard work <sup>0</sup> Unable to perform any of the above activities due to knee pain											
2.	Dur	ing the	past 4	weeks, o	or since	your inj	ury, how	v often h	ave you	had pai	n?		
Nev	/er	10	9 <b>□</b>	8	7	6 <b>□</b>	5 <b>□</b>	4	3 <b></b>	2	1	0	Constant
3.	If y	ou have	pain, I	now sev	ere is it'	?							
No	pain	10	9	8	7	6 <b>□</b>	5 <b></b>	4	3	2	1	0	Worst pain imaginable
4.	During the past 4 weeks, or since your injury, how stiff or swollen was your knee?  4 Not at all  3 Mildly  2 Moderately  1 Very  0 Extremely												
5.	Wha	at is the	highes	st level o	of activit	y you ca	an perfo	rm witho	out signif	icant sw	elling in	your kno	ee?
	<sup>4</sup> □Very strenuous activities like jumping or pivoting as in basketball or soccer <sup>3</sup> □Strenuous activities like heavy physical work, skiing or tennis <sup>2</sup> □Moderate activities like moderate physical work, running or jogging <sup>1</sup> □Light activities like walking, housework, or yard work <sup>0</sup> □Unable to perform any of the above activities due to knee swelling												
6.	Dur	ing the	past 4	weeks, o	or since	your inj	ury, did	your kne	ee lock o	r catch?	•		
			₀ <b>□</b> Ye	S 1	No								
7.	Wha	at is the	4 □ Vei 3 □ Str 2 □ Mo 1 □ Lig	ry strent enuous derate a ht activi	ious act activities ictivities ties like	ivities lil s like he like mo walking	ke jumpi avy phys derate p , house	ng or pi sical wor bhysical work or y	out signif voting as k, skiing work, rui yard wor es due t	s in bask or tenr nning or k	ketball or nis jogging	soccer	

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4□Very strenuous activities like jumping or pivoting as in basketball or soccer

3 ☐ Strenuous activities like heavy physical work, skiing or tennis

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

## **SPORTS ACTIVITIES**:

										g or jogging		
						walking, he any of the				nee		
9.	Цом	door you	ır kna	oo affoc	t vour a	hility to:						
9.	HOW	w does your knee affect your ability to:						difficult t all	Minimally difficult	Moderately Difficult	Extreme difficul	•
	a.	Go up :	stairs				í —		3 <b></b>	2	1	<u>t</u> to do
	b.	Go dow	down stairs				4		3	2	1	0
	C.	Kneel on the front of your knee					4		3	2	1	0
	d.	Squat Sit with your knee bent					4		3	2	1	0
	e.	Sit with your knee bent					4		3	2	1	0
	f.	f. Rise from a chair g. Run straight ahead				4 🗆		3	2	1	0	
	g.							3 <b></b>	2	1	$\square_0$	
	h.					lved leg	4		3	2	1	$\square_0$
	i.	Stop ar	Stop and start quickly				4		3	2	1	$\Box_0$
	and (		he in	ability to	perfor	m any of y				with 10 being vhich may includ		cellent function
					4	5		7 8	9 10	No limitation in daily activities		
CUF	RREN	Γ FUNCT	ION (	of Your	R KNEE:							
		erform vities	0	1	2	3	4	5		7 8	9 10	No limitation in daily activities