

FORM ID	PS-EBJ-20161026-003									
Please hand-print with capital letters										
Patient's First Name										
PN0001	D	O	N	A	L	D				
Patient's Last Name										
PN0002	T	R	U	M	P					
Patient's Date Of Birth										
DOB0003	0	6	/	1	4	/	1	9	4	6
Date of Survey										
DS001	1	1	/	0	8	/	2	0	1	6
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 knee joint.										
1. How severe is your knee joint stiffness after first wakening in the morning?										
KS001	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
Pain: What amount of knee pain have you experienced the last week during the following activities?										
2. Twisting/pivoting on your knee										
KP001	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
3. Straightening knee fully										
KP002	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
4. Going up or down stairs										
KP003	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
5. Standing upright										
KP004	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
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.										
6. Rising from sitting										
KP005	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe	<input type="checkbox"/> Extreme					
7. Bending to floor/pick up an object										
KP006	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input checked="" type="checkbox"/> Extreme					