# Walking Scale Questionnaire

These questions ask about limitations to your walking due to knee pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

| In the past 2 weeks, how much has your knee pain… | Not at all | A little | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| Limited your ability to walk? | 1 | 2 | 3 | 4 | 5 |
| Limited your ability to run? | 1 | 2 | 3 | 4 | 5 |
| Limited your ability to climb up or down stairs? | 1 | 2 | 3 | 4 | 5 |
| Made standing when doing things more difficult? | 1 | 2 | 3 | 4 | 5 |
| Limited your balance when standing or walking? | 1 | 2 | 3 | 4 | 5 |
| Limited how far you are able to walk? | 1 | 2 | 3 | 4 | 5 |
| Increased the effort needed for you to walk? | 1 | 2 | 3 | 4 | 5 |
| Made it necessary for you to use support when walking indoors (e.g. holding on to furniture, using a cane, etc.)? | 1 | 2 | 3 | 4 | 5 |
| Made it necessary for you to use support when walking outdoors (e.g. using a cane or walker, etc.)? | 1 | 2 | 3 | 4 | 5 |
| Slowed down your walking? | 1 | 2 | 3 | 4 | 5 |
| Affected how smoothly you walk? | 1 | 2 | 3 | 4 | 5 |
| Made you concentrate on your walking? | 1 | 2 | 3 | 4 | 5 |

Thank you for completing this questionnaire

WALKING SCALE DISABILITY SCORE: < NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

# Knee Pain Program Qualification Questionnaire

(Please answer ALL the following questions by circling one answer per question.)

Thank you for completing this questionnaire. Please return to the front desk.

1. Do you experience knee pain? Right / Left / Both
2. Do you experience knee pain at rest? Yes / No
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? Yes / No / Unsure
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months? Yes / No
5. Do you have morning knee stiffness lasting 30 minutes or less? Yes / No
6. Do you experience a grinding sensation with knee movement? Yes / No
7. Have you tried pain and/or anti-inflammatory medications (i.e.: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief? Yes / No
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? Yes / No
9. Have you attempted to lose weight to help with your knee pain? Yes / No
10. Have you used a knee brace without long-term relief? Yes / No
11. Has your doctor ever drained excess fluid from the affected knee(s)? Yes / No
12. Have you tried steroid/cortisone injection(s) to the knee without long-term relief? Yes / No