

Rehabilitation Protocol for Meniscus Repair

This protocol is intended to guide clinicians and patients through the post-operative course for a meniscus repair. Specific intervention should be based on the needs of the individual and should consider exam findings and clinical decision making. If you have questions, contact the referring physician.

Considerations for the Post-operative Meniscal Repair Program

Many different factors influence the post-operative meniscal repair rehabilitation outcomes, including type and location of the meniscal tear and repair. Consider taking a more conservative approach to range of motion, weight bearing, and rehab progression with more complex tears, all-inside meniscal repairs, and meniscal transplants. It is recommended that clinicians collaborate closely with the referring physician regarding intra-operative findings and satisfaction with the strength of the repair.

Post-operative considerations

If you develop a fever, intense calf pain, excessive drainage from the incision, uncontrolled pain or any other symptoms you have concerns about you should call your doctor.

PHASE I: IMMEDIATE POST-OP (0-2 WEEKS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Protect repair • Reduce swelling, minimize pain • Restore patellar mobility • Restore full extension • Flexion < 90 degrees • Minimize arthrogenic muscle inhibition, re-establish quad control, regain full active extension • Patient education <ul style="list-style-type: none"> • Keep your knee straight and elevated when sitting or lying down. Do not rest with a towel placed under the knee • Do not actively bend your knee; support your surgical side when performing transfers (i.e. sitting to laying down) • Do not pivot on your surgical side
Weight Bearing	<p><i>Walking</i></p> <ul style="list-style-type: none"> • Brace locked, crutches • Partial weight bearing • When climbing stairs, make sure you are leading with the non-surgical side when going up the stairs, make sure you are leading with the crutches and surgical side when going down the stairs
Intervention	<p><i>Swelling Management</i></p> <ul style="list-style-type: none"> • Ice, compression, elevation (check with MD re: cold therapy) • Retrograde massage • Ankle pumps <p><i>Range of motion/Mobility</i></p> <ul style="list-style-type: none"> • Patellar mobilizations: superior/inferior and medial/lateral • Seated assisted knee flexion extension and heel slides with towel <ul style="list-style-type: none"> ○ ***Avoid active knee flexion to prevent hamstring strain to the posteromedial joint • Low intensity, long duration extension stretches: prone hang, heel prop • Supine passive hamstring stretch <p><i>Strengthening</i></p> <ul style="list-style-type: none"> • Quad sets • NMES high intensity (2500 Hz, 75 bursts) supine knee extended 10 sec/50 sec, 10 contractions, 2x/wk during sessions—use of clinical stimulator during session, consider home units distributed immediate post op

	<ul style="list-style-type: none"> • Straight leg raise <ul style="list-style-type: none"> ◦ **Do not perform straight leg raise if you have a knee extension lag • Hip abduction • Multi-angle isometrics 90 and 60 deg knee extension
Criteria to Progress	<ul style="list-style-type: none"> • Knee extension ROM 0 deg • Knee flexion ROM 90 degrees • Quad contraction with superior patella glide and full active extension • Able to perform straight leg raise without lag

PHASE II: INTERMEDIATE POST-OP (3-5 WEEKS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Continue to protect repair • Reduce pain, minimize swelling • Maintain full extension • Flexion < 120 degrees
Weight Bearing	<p><i>Walking</i></p> <ul style="list-style-type: none"> • Continue partial weight bearing • Consult with referring MD regarding unlocking brace
Additional Intervention <i>*Continue with Phase I interventions</i>	<p><i>Range of motion/Mobility</i></p> <ul style="list-style-type: none"> • Stationary bicycle: gentle range of motion only (see Phase III for conditioning) <p><i>Cardio</i></p> <ul style="list-style-type: none"> • Upper body ergometer <p><i>Strengthening</i></p> <ul style="list-style-type: none"> • Calf raises • Lumbopelvic strengthening: sidelying hip external rotation-clamshell, plank <p><i>Balance/proprioception</i></p> <ul style="list-style-type: none"> • Double limb standing balance utilizing uneven surface (wobble board) • Joint position re-training
Criteria to Progress	<ul style="list-style-type: none"> • No swelling (Modified Stroke Test) • Flexion ROM 120 degrees • Extension ROM equal to contra lateral side

PHASE III: LATE POST-OP (6-8 WEEKS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Continue to protect repair • Maintain full extension • Normalize gait • Flexion within 10 degrees of contra lateral side • Safely progress strengthening • Promote proper movement patterns • Avoid post exercise pain/swelling
Weight Bearing	<ul style="list-style-type: none"> • May discontinue use of brace/crutches after 6 wks per MD and once adequate quad control is achieved
Additional Intervention <i>*Continue with Phase I-II Interventions</i>	<p><i>Range of motion/Mobility</i></p> <ul style="list-style-type: none"> • Supine active hamstring stretch • Standing gastroc stretch and soleus stretch • Gentle stretching all muscle groups: prone quad stretch, standing quad stretch, kneeling hip flexor stretch • Rotational tibial mobilizations if limited ROM <p><i>Cardio</i></p> <ul style="list-style-type: none"> • Stationary bicycle, flutter kick swimming, pool jogging <p><i>Strengthening</i></p> <ul style="list-style-type: none"> • Partial squat exercise 0-60 degrees • Ball squats, wall slides, mini squats from 0-60 deg • Hamstring strengthening: prone hamstring curls

	<ul style="list-style-type: none"> • Lumbopelvic strengthening: bridges on physioball, bridge on physioball with roll-in, bridge on physioball alternating, hip hike • Gym equipment: leg press machine, hip abductor and adductor machine, hip extension machine, roman chair, seated calf machine • Progress intensity (strength) and duration (endurance) of exercises <p><i>Balance/proprioception</i></p> <ul style="list-style-type: none"> • Single limb balance progress to uneven surface including perturbation training
Criteria to Progress	<ul style="list-style-type: none"> • No swelling/pain after exercise • Normal gait • ROM equal to contra lateral side • Joint position sense symmetrical (<5 degree margin of error)

PHASE IV: TRANSITIONAL (9-12 WEEKS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Maintain full ROM • Safely progress strengthening • Promote proper movement patterns • Avoid post exercise pain/swelling
Additional Intervention <i>*Continue with Phase I-III interventions</i>	<p><i>Cardio</i></p> <ul style="list-style-type: none"> • Elliptical, stair climber <p><i>Strengthening</i></p> <ul style="list-style-type: none"> ○ **The following exercises to focus on proper control with emphasis on good proximal stability • Squat to chair • Lateral lunges • Single leg progression: partial weight bearing single leg press, slide board lunges: retro and lateral, step ups and step ups with march, lateral step-ups, step downs, single leg squats, single leg wall slides • Knee Exercises for additional exercises and descriptions • Gym equipment: seated hamstring curl machine and hamstring curl machine • Romanian deadlift
Criteria to Progress	<ul style="list-style-type: none"> • No episodes of instability • Maintain quad strength • 10 repetitions single leg squat proper form through at least 60 deg knee flexion • KOOS-sports questionnaire >70% • Functional Assessment <ul style="list-style-type: none"> ○ Quadriceps index >80%; HHD mean preferred (isokinetic testing if available) ○ Hamstring, glut med,glut max index ≥80%; HHD mean preferred (isokinetic testing for HS if available) ○ Single leg hop test ≥75% compared to contra lateral side (earliest 12 wks)

PHASE V: EARLY RETURN TO SPORT (3-5 MONTHS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Safely progress strengthening • Safely initiate sport specific training program • Promote proper movement patterns • Avoid post exercise pain/swelling
Additional Intervention <i>*Continue with Phase II-IV interventions</i>	<ul style="list-style-type: none"> • Interval running program <ul style="list-style-type: none"> ○ Return to Running Program • Progress to plyometric and agility program (with functional brace if prescribed) <ul style="list-style-type: none"> ○ Agility and Plyometric Program

Criteria to Progress	<ul style="list-style-type: none"> • Clearance from MD and ALL milestone criteria below have been met • Completion jog/run program without pain/swelling • <u>Functional Assessment</u> <ul style="list-style-type: none"> ○ Quad/HS/glut index $\geq 90\%$; HHD mean preferred (isokinetic testing if available) ○ Hamstring/Quad ratio $\geq 70\%$; HHD mean preferred (isokinetic testing if available) ○ Hop Testing $\geq 90\%$ compared to contra lateral side • <u>KOOS-sports questionnaire</u> $>90\%$ • <u>International Knee Committee Subjective Knee Evaluation</u> >93 • <u>Psych Readiness to Return to Sport (PRRS)</u>
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PHASE VI: UNRESTRICTED RETURN TO SPORT (6+ MONTHS AFTER SURGERY)

Rehabilitation Goals	<ul style="list-style-type: none"> • Continue strengthening and proprioceptive exercises • Symmetrical performance with sport specific drills • Safely progress to full sport
Additional Intervention <i>*Continue with Phase II-V interventions</i>	<ul style="list-style-type: none"> • Multi-plane sport specific plyometrics program • Multi-plane sport specific agility program • Include hard cutting and pivoting depending on the individuals' goals • Non-contact practice → Full practice → Full play
Criteria to Progress	<ul style="list-style-type: none"> • Last stage, no additional criteria

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Contact	Please call 617.643.9999 with any questions specific to this protocol
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References

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Functional Assessment

Patient Name: _____

MRN: _____

Date of Surgery: _____

Surgeon: _____

Graft Type (circle):	Autograft	Hamstring	BPTB	Quad
	Allograft	Achilles	BPTB	Other

Concomitant Injuries/Procedures: _____

	Operative Limb	Non-operative Limb	Limb Symmetry Index
Range of motion (X-0-X)			-
Pain (0-10)			-
Knee Effusion			-
Hamstring Strength (average/3 trials)			
Quadriceps Strength (average/3 trials)			
Hamstring : Quadriceps Ratio (as above)			-
Hop Testing			
Single-leg Hop for Distance			
Triple Hop for Distance			
Crossover Hop for Distance			
Vertical Jump			
Y-Balance Test			
Calculated 1 RM (single leg press)			
Psych. Readiness to Return to Sport (PRRS)			

Ready to jog? YES NO

Ready to return to sport? YES NO

Recommendations: _____

Examiner: _____

Range of motion is recorded in X-0-X format: for example, if a patient has 6 degrees of hyperextension and 135 degrees of flexion, ROM would read: 6-0-135. If the patient does not achieve hyperextension, and is lacking full extension by 5 degrees, the ROM would simply read: 5-135.

Pain is recorded as an average value over the past 2 weeks, from 0-10. 0 is absolutely no pain, and 10 is the worst pain ever experienced.

Knee Effusion is tested using the Modified Stroke Test. An upstroke is applied to medial side of knee, followed by downstroke on lateral side. The therapist observes for movement of fluid with each stroke.

- 0: no wave produced with downward stroke
- Trace: small wave of fluid on medial side of knee
- 1+: large bulge of fluid on medial side of knee with downstroke
- 2+: Effusion returns to medial side of knee without downstroke
- 3+: inability to move effusion from medial side of knee

Quadriceps strength is measured using a handheld dynamometer. The patient is secured in 60 degrees of knee flexion and the HHD is placed between the patient's tibia and the resistance arm, 1 inch proximal to the midline between the malleoli. The patient is instructed to apply a maximal isometric effort force the HHD and the average of 3 trials is recorded for each limb.

Hamstring strength is measured using a handheld dynamometer. The patient is secured in 60 degrees of knee flexion and the HHD is placed between the patient's lower leg and the resistance arm, 1 inch proximal to the midline between the malleoli. The patient is instructed to apply a maximal isometric force against the HHD and the average of 3 trials is recorded for each limb.

Hamstring:quadriceps ratio is calculated for each limb based on the average of 3 trials for flexion and extension, respectively. The average isometric hamstring strength is divided by the average quadriceps strength.

Hop testing is performed per standardized testing guidelines. The average of 3 trials is recorded to the nearest centimeter for each limb.

Return to Running Program

This program is designed as a guide for clinicians and patients through a progressive return-to-run program. Patients should demonstrate > 80% on the Functional Assessment prior to initiating this program (after a knee ligament or meniscus repair). Specific recommendations should be based on the needs of the individual and should consider clinical decision making. If you have questions, contact the referring physician.

PHASE I: WARM UP WALK 15 MINUTES, COOL DOWN WALK 10 MINUTES

Day	1	2	3	4	5	6	7
Week 1	W5/J1x5		W5/J1x5		W4/J2x5		W4/J2x5
Week 2		W3/J3x5		W3/J3x5		W2/J4x5	
Week 3	W2/J4x5		W1/J5x5		W1/J5x5		Return to Run

Key: W=walk, J=jog

****Only progress if there is no pain or swelling during or after the run**

PHASE II: WARM UP WALK 15 MINUTES, COOL DOWN WALK 10 MINUTES

Week	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	20 min		20 min		20 min		25 min
2		25 min		25 min		30 min	
3	30 min		30 min		35 min		35 min
4		35 min		40 min		40 min	
5	40 min		45 min		45 min		45 min
6		50 min		50 min		50 min	
7	55 min		55 min		55 min		60 min
8		60 min		60 min			

Recommendations

- Runs should occur on softer surfaces during Phase I
- Non-impact activity on off days
- Goal is to increase mileage and then increase pace; avoid increasing two variables at once
- 10% rule: no more than 10% increase in mileage per week

Agility and Plyometric Program

This program is designed as a guide for clinicians and patients through a progressive series of agility and plyometric exercises to promote successful return to sport and reduce injury risk. Patients should demonstrate > 80% on the Functional Assessment prior to initiating this program. Specific intervention should be based on the needs of the individual and should consider clinical decision making. If you have questions, contact the referring physician.

PHASE I: ANTERIOR PROGRESSION

Rehabilitation Goals	<ul style="list-style-type: none"> • Safely recondition the knee • Provide a logical sequence of progressive drills for pre-sports conditioning
Agility	<ul style="list-style-type: none"> • Forward run • Backward run • Forward lean in to a run • Forward run with 3-step deceleration • Figure 8 run • Circle run • Ladder
Plyometrics	<ul style="list-style-type: none"> • Shuttle press: Double leg→alternating leg→single leg jumps • Double leg: <ul style="list-style-type: none"> ○ Jumps on to a box→ jump off of a box→ jumps on/off box ○ Forward jumps, forward jump to broad jump ○ Tuck jumps ○ Backward/forward hops over line/cone • Single leg (these exercises are challenging and should be considered for more advanced athletes): <ul style="list-style-type: none"> ○ Progressive single leg jump tasks ○ Bounding run ○ Scissor jumps ○ Backward/forward hops over line/cone
Criteria to Progress	<ul style="list-style-type: none"> • No increase in pain or swelling • Pain-free during loading activities • Demonstrates proper movement patterns

PHASE II: LATERAL PROGRESSION

Rehabilitation Goals	<ul style="list-style-type: none"> • Safely recondition the knee • Provide a logical sequence of progressive drills for the Level 1 sport athlete
Agility <i>*Continue with Phase I interventions</i>	<ul style="list-style-type: none"> • Side shuffle • Carioca • Crossover steps • Shuttle run • Zig-zag run • Ladder
Plyometrics <i>*Continue with Phase I interventions</i>	<ul style="list-style-type: none"> • Double leg: <ul style="list-style-type: none"> ○ Lateral jumps over line/cone ○ Lateral tuck jumps over cone • Single leg (these exercises are challenging and should be considered for more advanced athletes): <ul style="list-style-type: none"> ○ Lateral jumps over line/cone ○ Lateral jumps with sport cord
Criteria to Progress	<ul style="list-style-type: none"> • No increase in pain or swelling • Pain-free during loading activities • Demonstrates proper movement patterns

PHASE III: MULTI-PLANAR PROGRESSION

Rehabilitation Goals	<ul style="list-style-type: none">• Challenge the Level 1 sport athlete in preparation for final clearance for return to sport
Agility <i>*Continue with Phase I-II interventions</i>	<ul style="list-style-type: none">• Box drill• Star drill• Side shuffle with hurdles
Plyometrics <i>*Continue with Phase I-II interventions</i>	<ul style="list-style-type: none">• Box jumps with quick change of direction• 90 and 180 degree jumps
Criteria to Progress	<ul style="list-style-type: none">• Clearance from MD• <u>Functional Assessment</u><ul style="list-style-type: none">○ Quad/HS/glut index $\geq 90\%$ contra lateral side (isokinetic testing if available)○ Hamstring/Quad ratio $\geq 70\%$○ Hop Testing $\geq 90\%$ contralateral side• KOOS-sports questionnaire $>90\%$• International Knee Committee Subjective Knee Evaluation >93• <u>Psych Readiness to Return to Sport (PRRS)</u>

KOOS KNEE SURVEY

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 you feel about your knee and how well you are able to perform your usual 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.

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

S4. Can you straighten your knee fully?

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

S5. Can you bend your knee fully?

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

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.

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

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

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

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

Pain

P1. How often do you experience knee pain?

Never	Monthly	Weekly	Daily	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P3. Straightening knee fully

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

P4. Bending knee fully

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

P5. Walking on flat surface

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

P6. Going up or down stairs

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

P7. At night while in bed

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

P8. Sitting or lying

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

P9. Standing upright

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

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A2. Ascending stairs

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

A3. Rising from sitting

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

A4. Standing

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

A5. Bending to floor/pick up an object

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

A6. Walking on flat surface

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

A7. Getting in/out of car

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

A8. Going shopping

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

A9. Putting on socks/stockings

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

A10. Rising from bed

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

A11. Taking off socks/stockings

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

A12. Lying in bed (turning over, maintaining knee position)

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

A13. Getting in/out of bath

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

A14. Sitting

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

A15. Getting on/off toilet

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 (moving heavy boxes, scrubbing floors, etc)

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

A17. Light domestic duties (cooking, dusting, etc)

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

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP2. Running

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

SP3. Jumping

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

SP4. 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"/>

SP5. Kneeling

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

Quality of Life

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

Never	Monthly	Weekly	Daily	Constantly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Not at all	Mildly	Moderately	Severely	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3. How much are you troubled with lack of confidence in your knee?

Not at all	Mildly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4. In general, how much difficulty do you have with your knee?

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

Thank you very much for completing all the questions in this questionnaire.

2000 IKDC SUBJECTIVE KNEE EVALUATION FORM

Your Full Name _____

Today's Date: ____/____/____
Day Month Year

Date of Injury: ____/____/____
Day Month Year

SYMPTOMS*:

*Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activities at this level.

1. What is the highest level of activity that you can perform without significant knee pain?

- 4 ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 ☐ Strenuous activities like heavy physical work, skiing or tennis
- 2 ☐ Moderate activities like moderate physical work, running or jogging
- 1 ☐ Light activities like walking, housework or yard work
- 0 ☐ 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?

Never	0	1	2	3	4	5	6	7	8	9	10	Constant
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

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. What is the highest level of activity you can perform without significant swelling in your knee?

- 4 ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 ☐ Strenuous activities like heavy physical work, skiing or tennis
- 2 ☐ Moderate activities like moderate physical work, running or jogging
- 1 ☐ Light activities like walking, housework, or yard work
- 0 ☐ 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?

- 0 ☐ Yes
- 1 ☐ No

7. What is the highest level of activity you can perform without significant giving way in your knee?

- 4 ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
- 3 ☐ Strenuous activities like heavy physical work, skiing or tennis
- 2 ☐ Moderate activities like moderate physical work, running or jogging
- 1 ☐ Light activities like walking, housework or yard work
- 0 ☐ Unable to perform any of the above activities due to giving way of the knee

SPORTS ACTIVITIES:

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

- 4 ☐ Very strenuous activities like jumping or pivoting as in basketball or soccer
3 ☐ Strenuous activities like heavy physical work, skiing or tennis
2 ☐ Moderate activities like moderate physical work, running or jogging
1 ☐ Light activities like walking, housework or yard work
0 ☐ 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	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b.	Go down stairs	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c.	Kneel on the front of your knee	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d.	Squat	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e.	Sit with your knee bent	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
f.	Rise from a chair	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
g.	Run straight ahead	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
h.	Jump and land on your involved leg	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
i.	Stop and start quickly	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

FUNCTION:

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:

	0	1	2	3	4	5	6	7	8	9	10	
Couldn't perform daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No limitation in daily activities

CURRENT FUNCTION OF YOUR KNEE:

	0	1	2	3	4	5	6	7	8	9	10	
Can't perform daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No limitation in daily activities

Psychological Readiness to Return to Sport

Patient Name: _____

MRN: _____

Surgery: _____

Date of Surgery: _____

Surgeon: _____

Please rate your confidence to return to your sport on a scale from 0 – 100

Example: 0 = No confidence at all
 50 = Moderate confidence
 100 = Complete confidence

1. My overall confidence to play is _____
2. My confidence to play without pain is _____
3. My confidence to give 100% effort is _____
4. My confidence to not concentrate on the injury is _____
5. My confidence in the injured body part to handle demands of the situation is _____
6. My confidence in my skill level/ability is _____

Total: _____

Score: _____

Examiner: _____