Patient: ____ **Date:** ____________

Lysholm Knee Rating System

By completing this questionnaire, your therapist will gain information as to how your knee functions during normal activities. Mark **one** box which best describes your knee function today.

LIMP (5 points)

☐	None	5
☐	Slight or periodic	3
☐	Severe and constant	0

SUPPORT (5 points)

☐	None	5
☐	Cane or crutch needed	2
☐	Weight bearing impossible	0

LOCKING (15 points)

☐	None	15
☐	Catching sensation, but no locking	10
☐	Locking occasionally	6
☐	Locking frequently	2
☐	Locked joint at examination	0

INSTABILITY (25 points)

☐	Never gives way	25
☐	Rarely during athletic activities/physical exertion	20
☐	Frequently during athletic activities/physical exertion	15
☐	Occasionally during daily activities	10
☐	Often during daily activities	5
☐	Every step	0

PAIN (25 points)

☐	None	25
☐	Intermittent and light during strenuous activities	20
☐	Marked during strenuous activities	15
☐	Marked during or after walking more than 1-2 miles	10
☐	Marked during or after walking less than 1-2 miles	5
☐	Constant	0

SWELLING (10 points)

☐	None	10
☐	After strenuous activities	6
☐	After ordinary activities	2
☐	Constant	0

STAIRS (10 points)

☐	No problem	10
☐	Slight problem	6
☐	One step at a time	2
☐	Impossible	0

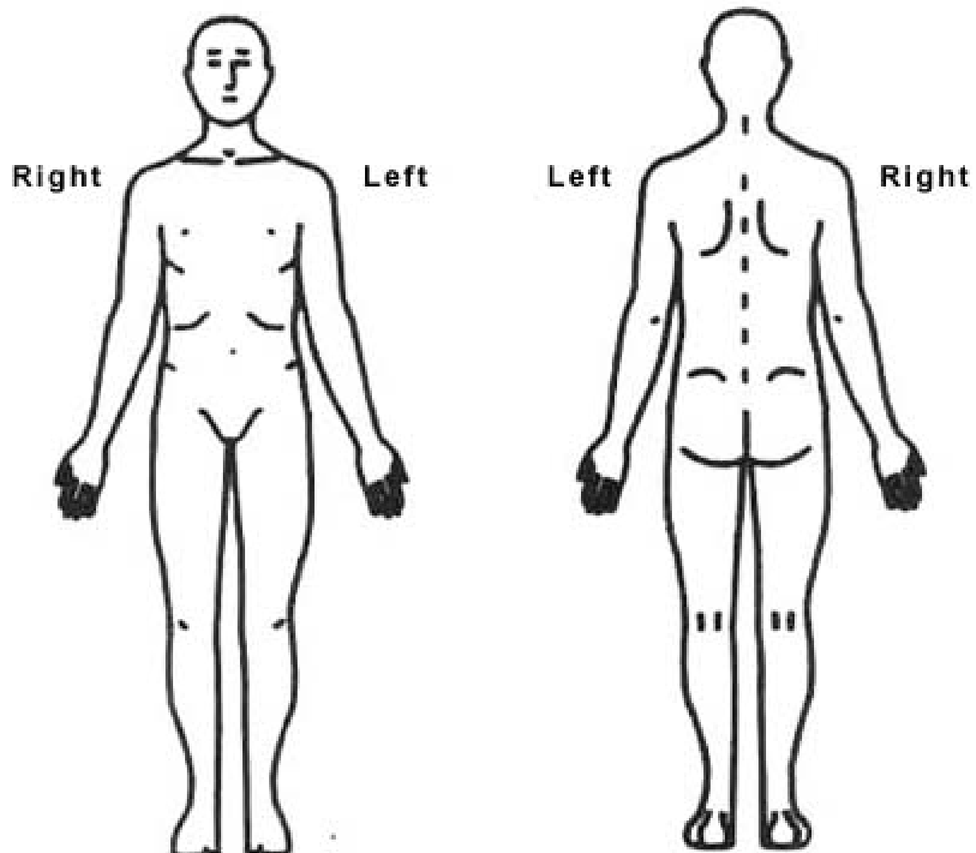
SQUATTING (5 points)

☐	No problem	5
☐	Slight Problem	4
☐	Not beyond 90° of flexion of the knee (halfway)	2
☐	Impossible	0

Pain Levels

10	Pain so intense you will go unconscious shortly.
9	Pain so intense you cannot tolerate it and demand pain killers or surgery.
8	Pain so intense you can no longer think clearly at all.
7	Intense pain causing you to think unclearly about half the time.
6	Piercing pain that causes you to think somewhat unclearly.
5	Strong deep pain that makes you pre-occupied with trying to manage it. Your normal lifestyle is curtailed.
4	Strong pain like an average toothache.
3	Very noticeable pain, like an accidental cut or blow to the nose.
2	Minor pain like lightly pinching the fold of skin between the fingers.
1	Very light barely noticeable pain.
0	No pain.

Please **mark** area of pain with an X and **label** with numbers.



Prior Therapy Form

Patient Name: ____

Date: __________________________

Are you currently a resident of a skilled nursing home? Yes No

Are you currently receiving home health care? Yes No

Please indicate if you have had any prior physical therapy or chiropractic care:

(Please include both inpatient and outpatient therapy)

Dates	**Locations**

Patient Signature: ____