**Appendix 2.** Patient questionnaire

Date: / / Time: Study #:

*Please complete one form every day around noon.*

*Please answer the following questions about pain you have had in the past 24 hours.*

The following questions refer to your **right** knee:

Q1 Right. On this scale, please indicate the **worst** pain you have had in the past 24 hours.

 *no pain* 0 10 *worst pain*

 *possible*

Q2 Right. On this scale, how much pain did you having **during physical therapy**?

 *no pain* 0 10 *worst pain*

 *possible*

The following questions refer to your **left** knee:

Q1 Left. On this scale, please indicate the **worst** pain you have had in the past 24 hours.

 *no pain* 0 10 *worst pain*

 *possible*

Q2 Left. On this scale, how much pain did you having **during physical therapy**?

 *no pain* 0 10 *worst pain*

 *possible*