

Sub	ject	ID			
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Please use black pen only to complete the form. Thank you

Today's Date	Surgeon ID Site Number
Month Day Year	State Andrews your passes are passes and the passes are passes and the
First Name	Last Name
Home Address (Number and Street)	
Home Address (Apt. #)	
City	State Zip Code
Primary Phone Number	Secondary Phone Number
(
Email Address	
Sex O Female O Male	
Age Date of Birth	/
Height (inches) Weight (lbs)	
Race	Are you Hispanic or Latino?
O White	O Yes
O Black or African American	O No
O Asian	O Prefer not to answer
O American Indian or Native Alaskan	
O Native Hawaiian or Pacific Islander	SSN (optional - for follow-up purposes only)
O Prefer not to answer	
O Other, specify	Form Date 04/2015 Page 1 of 10



	Prospective Cohort	Subject ID						
	Initial Form (Patient, Child)			- [] -	
Date of Visit Month Day Year	Study Visit: Baseline							
	KNEE							
Has anyone in your birth fam O No O Sister(s) O Don't know O Brother(s)	ily had osteochondritis dissecans? Chec	k all	that	appl	y.			
O Mother O Grandmother(s)								
•								
O Father O Grandfather(s)								
Have you been diagnosed with O Yes O No	h an OCD lesion in any joint before?							
If yes, which joint? O Other Knee O Shoulder O E	lbow O Hip O Ankle							
Are you experiencing knee pa	in?							
O Yes - Left O Yes - Right								
O No - Left O No - Right								
If yes, how long have you been	n experiencing knee pain, in months?							
If yes, did your knee pain star O Yes O No	t immediately following a knee injury?							
Have you received treatment to Yes O No	from anyone for your knee pain?							
If yes, how many people have	you seen?							
If yes, who have you seen?								

O Primary Care Physician

O Orthopaedic Surgeon

O Primary Care Sports Medicine Physician

O Athletic Trainer

O Chiropractor

O Physical Therapist

O Other



Sub	ject	ID			
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Pedi-IKDC SUBJECTIVE KNEE EVALUATION FORM

SYMPTOMS*

<u>SYMPTOMS</u> *:
1. What is the most you could do today without making your injured knee hurt a lot?
O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer
O Hard activities like heavy lifting, skiing or tennis
O Sort of hard activities like walking fast or jogging
O Light activities like walking at a normal speed
O I can't do any of the activities listed above because my knee hurts too much now
2. During the past 4 weeks, or since your injury, how much of the time did your injured knee hurt? O 0 (Never) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Hurt all the time)
0 (Never) 01 02 03 04 03 00 07 08 09 010 (Mart an the time)
3. How badly does your injured knee hurt today?
O 0 (No hurt at all) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Hurts so much I can't stand it)
4. During the past 4 weeks, or since your injury, how hard has it been to move or bend your injured knee?
O Not at all hard O A little hard O Somewhat hard O Very hard O Extremely hard
5. During the past 4 weeks, or since your injury, how puffy (or swollen) was your injured knee? O Not at all puffy
O A little puffy
O Somewhat puffy
O Very puffy
O Extremely puffy
6. What is the most you could do today without making your injured knee puffy (or swollen)?
O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer
O Hard activities like heavy lifting, skiing or tennis
O Sort of hard activities like walking fast or jogging
O Light activities like walking at a normal speed

O I can't do any of the activities listed above because my injured knee is puffy even when I rest



Prospective Cohort					
Initial Form (Patient, Child)					

Sub	ject	t ID			
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7. During the past 4 weeks, or sincYes	e your injury,	did your knee ever	get stuck in place (lo	ock) so you cou	ld not move it?
O No 8. During the past 4 weeks, or since yo O Yes	ur injury, did y	our knee ever feel lik	e it was getting stuck (e	catching) but you	ı could still move it?
O No					
What is the most you could doVery hard activities like jumpin			-	-	
O Hard activities like heavy lifting	g, skiing or te	nnis			
O Sort of hard activities like walki	ng fast or jog	ging			
O Light activities like walking at a	normal spee	d			
O I can't do any of the activities lis	sted above be	cause my injured k	nee is puffy even wh	en I rest	
SPORTS ACTIVITIES:		, ,			
10. What is the most you can do O Very hard activities like jumping O Hard activities like heavy lifting O Sort of hard activities like walking at a	g or turning for s, skiing or ter ng fast or jog	ast to change direct nnis ging		ll or soccer	
O I can't do any of the activities lis	_		nee is puffy even wh	en I rest	
	o, not at all	Yes, a little	Yes, somewhat	Yes, a lot	I can't do this
affect your ability to: a. Go up stairs?	0	0	0	0	0
b. Go down stairs?	0	0	0	0	0
c. Kneel on your injured knee?d. Squat down like a baseball	0	0	0	0	0
catcher?	0	0	0	0	0
e. Sit in a chair with your knees bent and feet flat on the floor?	0	0	0	0	0
f. Get up from a chair?	0	0	0	0	0
g. Run?	0	0	0	0	0
h. Jump and land on your injured knee?	0	0	0	0	0
i. Stop and start moving quickly? ROCK Prospective Cohort	0	0	O Form Dat	O e 04/2015 Page	O 4 of 10



Dratt			Prospective Cohort					Subject ID		
			Initial Fo	•]-[]		
12. How well	did you	r knee work	before you i	njured it	?					
0 1	2	3 4	-	6	7	8	9	10		
O O I could not do anything at all	0	0 (Ó	Ó	Ö	Ó	O I could do anything I wanted to		
13. How well	does you	ır knee work	now?							
0 1	2	3 4	5	6	7	8	9	10		
0 0	0	0 0		0	Ó	0	0	0		
I am not able to do anything at all								I am able to do anything I want to do		
14. Who comp	oleted the	e questionna	ire? O Chi	ild alone	O Chile	d with help	o from p	oarent/adult		
track of how	you feel question to a	about your l n by filling i answer a que	knee and ho n the appro estion, pleas	w well yo priate bu e give the	ou are ab bble, onle best an	de to perf ly <u>one</u> bul swer you	orm yo oble for can.	nation will help us keep ur usual activities. • each question. If you are week.		
S1. Do you ev		0 0		O Alwa	ys					
S2. Do you fe			-			se when yo	our kne	ee moves?		
S3. Does your				•	_					
S4. Can you s	_	•	•							
O Always O	Often	O Sometime:	s O Rarely	O Nev	er					
S5. Can you b	end you	r knee fully?	•							
O Always O	•	•		O Nev	er					
ROCK Pros			Ý				Form Da	te 04/2015 Page 5 of 10		



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Stiffness:

The following questions	concern the amount of	of joint stiffness	you have exp	erienced duri	ng the last v	veek in
your knee. Stiffness is a	sensation of restrictio	n or slowness in	the ease with	h which you r	nove vour ki	nee ioint.

				on or slowness in the ease with which you move you
		your knee join O Moderate		after first waking in the morning?
S7. How O None		your knee stiff O Moderate	fness after s O Severe	sitting, lying or resting later in the day? O Extreme
Pain:				
P1. How		you experience	•	
O Never	O Mont	hly O Weekl	y O Daily	O Always
What am	ount of ki	nee pain have y	ou experienc	eed the <u>last week</u> during the following activities?
P2. Twis	ting/pivo	ting on your k	nee	
O None	O Mild	O Moderate	O Severe	O Extreme
P3. Strai	ightening	knee fully		
	- 0	O Moderate	O Severe	O Extreme
P4 Rend	ling knee	fully		
	~	O Moderate	O Severe	O Extreme
ne 117 11				
	_	at surface O Moderate	O Severe	O Extreme
	•	• moderate	0 50,010	Dationio
	· .	own stairs	• •	
O None	O Mild	O Moderate	O Severe	O Extreme
P7. At ni	ight while	in bed		
O None	O Mild	O Moderate	O Severe	O Extreme
P8. Sittin	ıg or lyin;	9		
O None	O Mild	O Moderate	O Severe	O Extreme
P9. Stan	ding upri	ght		

O None O Mild O Moderate O Severe O Extreme



Sul	oject	t ID			
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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 <u>last week</u> due to your knee.

A1. Desc	ending st	airs		
O None	O Mild	O Moderate	O Severe	O Extreme
A2. Asce	ending sta	irs		
O None	O Mild	O Moderate	O Severe	O Extreme
	ng from si	_		
O None	O Mild	O Moderate	O Severe	O Extreme
A4. Stan	_			
O None	O Mild	O Moderate	O Severe	O Extreme
A5. Beno	ding to flo	or/pick up an	object	
	-	O Moderate	•	O Extreme
A6. Wall	king on fl	at surface		
O None	O Mild	O Moderate	O Severe	O Extreme
	ing in/out			
O None	O Mild	O Moderate	O Severe	O Extreme
A8. Goin	ıg shoppiı	ıg		
		O Moderate	O Severe	O Extreme
A9. Putti	ing on soc	ks/stockings		
	_	O Moderate	O Severe	O Extreme
A10. Ris	ing from l	bed		
O None	O Mild	O Moderate	O Severe	O Extreme
		ocks/stockings		
O None	O Mild	O Moderate	O Severe	O Extreme
A12. Lyi	ng in bed	(turning over	, maintainir	ng knee position)
O None	\bigcirc Mild	O Moderate	O Cavara	O Extrama



Sub	ject	t ID			
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For each of the following activities, please indicate the degree of difficulty you have experienced in the <u>last</u> <u>week</u> due to your knee.

week du	e to your k	tnee.						
	tting in/ou O Mild	nt of bath O Moderate	O Severe	O Extreme				
A14. Site	•	O Moderate	O Severe	O Extreme				
	tting on/o	ff toilet O Moderate	O Severe	O Extreme				
	•	stic duties (mo	-	boxes, scrubbing floors, etc) O Extreme				
_		tic duties (cool O Moderate		g, etc) O Extreme				
The following should b	<u>Function, sports and recreational activities:</u> 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 <u>last week</u> due to your knee.							
SP1. Squ O None	natting O Mild	O Moderate	O Severe	O Extreme				
SP2. Rui O None	0	O Moderate	O Severe	O Extreme				
SP3. Jun O None		O Moderate	O Severe	O Extreme				
		oting on your	-					
SP5. Kn	eeling							

O None O Mild O Moderate O Severe O Extreme



Prospective Cohort Initial Form (Patient, Child)	Subject ID

Quality of life:

Q1. How often are you aware of your knee problem?
Never O Monthly O Weekly O Daily O Constantly
Q2. Have your modified your life style to avoid potentially damaging activities to your knee?
Not at all O Mildly O Moderately O Severely O Totally
Q3. How much are you troubled with lack of confidence in your knee?
Not at all O Mildly O Moderately O Severely O Extremely
Q4. In general, how much difficulty do you have with your knee?
None O Mild O Moderate O Severe O Extreme



Subject	ID			
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FABS SCALE

Please indicate how often you performed each activity in your healthiest and most active state, in the past year.

	Less than one time in a month 0	One time in a month	One time in a week 2	2 or 3 times in a week 3	4 or more times in a week 4
Running: while playing a sport or jogging	9 0	0	0	0	0
Cutting: changing directions while running	g 0	0	0	0	0
Deceleration: coming t a quick stop while runn		0	0	0	0
Pivoting: turning your body with your foot planted while playing sport; For example: skii skating, kicking, throwi hitting a ball (golf, tenn squash), etc.	ng,	0	0	0	0
Duration: perform athle activity for as long as you would like to without stopping		0	0	0	0
Endurance: perform athletic activity for one whole hour without stopping	Ο	0	0	0	0

Competition: Do you participate in organized competitive sports or physical activities?

- O No (or gym class only)
- O Yes, but WITHOUT an official or judge (such as club or pickup games)
- O Yes, WITH an official or judge
- O Yes, at a national or professional level

Supervision: Do you participate in supervised sports practice or activities (other than gym class)?

- O No
- O Yes, 1-2 times per week
- O Yes, 3-4 times per week
- O Yes, 5 or more times per week



Sub	oject	t ID			
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Please use black pen only to complete the form. Thank you

Today's Date		Surgeon ID	**************************************	Site Number
Month Day Year		Algebras III		
First Name	Last Na	ıme		
Home Address (Number and Street)				
Home Address (Apt. #)				
City			4. 7:-	Cala
City			ate Zip	Code
Primary Phone Number		Secondary	Phone Numb	er
Email Address				
Sex O Female O Male				
Age Date of Birth]/			
Height (inches) Weight (lbs)				
Race	Are you Hispani	c or Latino?		
O White	O Yes			
O Black or African American	O No			
O Asian	O Prefer not to answ	er		
O American Indian or Native Alaskan			• .	
O Native Hawaiian or Pacific Islander	SSN (optional - 1	for follow-up p	urposes only)	•
O Prefer not to answer				
O Other, specify				
ROCK Prospective Cohort		Form	Date 08/2014	Page 1 of 9



Sub	ject	ID			
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Date of Visit	CA L XP M
	Study Visit:
Month Day Yea	Baseline
Month Bay 162	KNEE
	RINE.
Has anyone in your birth far	mily had osteochondritis dissecans? Check all that apply.
O No O Sister(s)	
O Don't know O Brother(s)	
O Mother O Grandmother(s)
O Father O Grandfather(s)	
Have you been diagnosed with O Yes O No	ith an OCD lesion in any joint before?
If yes, which joint? O Other Knee O Shoulder O	Elbow O Hip O Ankle
Are you experiencing knee p	pain?
O Yes - Left O Yes - Right	
O No - Left O No - Right	
If yes, how long have you be	en experiencing knee pain, in months?
If yes, did your knee pain sta	art immediately following a knee injury?
Have you received treatmen O Yes O No	t from anyone for your knee pain?
If yes, how many people hav	re you seen?
If yes, who have you seen?	
O Athletic Trainer	O Primary Care Physician O Other
O Physical Therapist	O Primary Care Sports Medicine Physician
O Chiropractor	O Orthopaedic Surgeon



Subject	ID			
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IKDC SUBJECTIVE KNEE EVALUATION FORM

THE CONTRACTOR OF THE CONTRACT
<u>SYMPTOMS</u> *: *Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activites at this level.
1. What is the highest level of activity that you can perform without significant knee pain?
O Very strenuous activities like jumping or pivoting as in basketball or soccer
O Strenuous activities like heavy physical work, skiing or tennis
O Moderate activities like moderate physical work, running or jogging
O Light activities like walking, housework or yard work
O 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? O 0 (Never) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Constant)
3. If you have pain, how severe is it?
00 (No pain) 01 02 03 04 05 06 07 08 09 010 (Worst pain imaginable)
4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?
O Not at all O Mildly O Moderately O Very O Extremely
 5. What is the highest level of activity you can perform without significant swelling in your knee? O Very strenuous activities like jumping or pivoting as in basketball or soccer O Strenuous activities like heavy physical work, skiing or tennis O Moderate activities like moderate physical work, running or jogging O Light activities like walking, housework, or yard work O 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?
O Yes

O No



Subject	ID			
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- 7. What is the highest level of activity you can perform without significant giving way in your knee?
- O Very strenuous activities like jumping or pivoting as in basketball or soccer
- O Strenuous activities like heavy physical work, skiing or tennis
- O Moderate activities like moderate physical work, running or jogging
- O Light activities like walking, housework or yard work
- O 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?
- O Very strenuous activities like jumping or pivoting as in basketball or soccer
- O Strenuous activities like heavy physical work, skiing or tennis
- O Moderate activities like moderate physical work, running or jogging
- O Light activities like walking, housework or yard work
- O 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:	0	0	0	0	0
b. Go down stairs:	0	0	0	0	0
c. Kneel on the front of knee:	0	0	0	0	0
d. Squat:	0	0	0	0	0
e. Sit with your knee bent:	0	0	0	0	0
f. Rise from a chair:	0	0	0	0	0
g. Run straight ahead	0	0	0	0	0
h. Jump and land on involved	leg: O	0	0	0	0
i. Stop and start quickly:	0	0	0	0	0



Sub	ject	t ID			
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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?

	FUN	CTION I	PRIOR T	o youi	R KNEE	INJURY	:				
	0	1	2	3	4	5	6	7	8	9	10
	0	0	0	0	0	0	0	0	0	0	0
Couldn't perf daily activitie											No limitation in daily activities
	CUR	RENT F	UNCTIC	N OF Y	OUR KN	IEE:					
	0	1	2	3	4	5	6	7	8	9	10
	0	0	0	0	0	0	0	0	0	0	0
Can't perform daily activities											No limitation in daily activities

KOOS KNEE SURVEY

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 filling in the appropriate bubble, only <u>one</u> bubble 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 <u>last week.</u>

S1. Do yo	u ever have	e swelling in you	ur knee?	
O Never	O Rarely	O Sometimes	O Often	O Always
S2. Do yo	u feel grind	ling, hear clicki	ing or any	other type of noise when your knee moves?
O Never	O Rarely	O Sometimes	O Often	O Always
S3. Does	your knee e	ever catch or ha	ng up whe	n moving?
O Never	O Rarely	O Sometimes	O Often	O Always
S4. Can y	ou straight	en your knee fu	ılly?	
O Always	O Often	O Sometimes	O Rarely	O Never
S5. Can y	ou bend yo	our knee fully?		
O Always	O Often	O Sometimes	O Rarely	O Never
ROCK	Prospective C	ohort		Form Date 08/2014 Page 5 of 9



Sub	ject	ID			
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L) L	11	111		т.

The following questions concern the amount of joint stiffness you have experienced during the <u>last week</u> in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

your kne	e. Sumes	is is a sensation	of restriction	on or slowness in the ease with which you move you
S6. How	severe is	your knee joir	nt stiffness 2	after first waking in the morning?
O None	O Mild	O Moderate	O Severe	O Extreme
				sitting, lying or resting later in the day?
O None	O Mild	O Moderate	O Severe	O Extreme
Pain:				
P1. How	often do	you experienc	e knee pain	?
		hly O Weeki	-	
What an	ount of ki	nee pain have y	ou experienc	ced the <u>last week</u> during the following activities?
P2. Twis	ting/pivo	ting on your k	nee	
O None	O Mild	O Moderate	O Severe	O Extreme
P3. Stra	ightening	knee fully		
O None	O Mild	O Moderate	O Severe	O Extreme
P4. Bend	ling knee	fully		
O None	O Mild	O Moderate	O Severe	O Extreme
P5. Wall	king on fl	at surface		
O None	O Mild	O Moderate	O Severe	O Extreme
P6. Goin	ıg up or d	own stairs		
O None	O Mild	O Moderate	O Severe	O Extreme
P7. At n	ight while	in bed		
O None	O Mild	O Moderate	O Severe	O Extreme
P8. Sitti	ng or lyin	\mathbf{g}		
O None	O Mild	O Moderate	O Severe	O Extreme
P9. Stan	ding upri	ght		

O None O Mild O Moderate O Severe O Extreme



Subject	ID			
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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 <u>last week</u> due to your knee.

A1. Desc	ending st	airs				
O None	O Mild	O Moderate	O Severe	O Extreme		
A2. Asce	nding sta	irs				
O None	O Mild	O Moderate	O Severe	O Extreme		
A3. Risin	ng from si	tting				
O None	O Mild	O Moderate	O Severe	O Extreme		
A4. Stan	ding					
O None	O Mild	O Moderate	O Severe	O Extreme		
A5. Beno	ling to flo	or/pick up an	object			
O None	O Mild	O Moderate	O Severe	O Extreme		
	_	at surface				
O None	O Mild	O Moderate	O Severe	O Extreme		
	ing in/out					
O None	O Mild	O Moderate	O Severe	O Extreme		
A8. Goir	ıg shoppiı	ıg				
O None	O Mild	O Moderate	O Severe	O Extreme		
A9. Putt	ing on soc	ks/stockings				
O None	O Mild	O Moderate	O Severe	O Extreme		
A10. Rising from bed						
O None	O Mild	O Moderate	O Severe	O Extreme		
A11. Taking off socks/stockings						
O None	O Mild	O Moderate	O Severe	O Extreme		
A12. Lyi	ng in bed	(turning over	, maintainiı	ng knee position)		
O None	O Mild	O Moderate	O Severe	O Extreme		



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For each of the following activities, please indicate the degree of difficulty you have experienced in the <u>last</u> <u>week</u> due to your knee.

Al3. Catting in/out of both

A13. Get	tting in/or	ıt of bath		
O None	O Mild	O Moderate	O Severe	O Extreme
A14. Sitt	ing			
O None	O Mild	O Moderate	O Severe	O Extreme
A15. Get	ting on/o	ff toilet		
O None	O Mild	O Moderate	O Severe	O Extreme
A16. Heavy domestic duties (moving heavy boxes, scrubb				

A16. Hea	ıvy domes	stic duties (mo	ving heavy	boxes, scrubbing floors, etc)
O None	O Mild	O Moderate	O Severe	O Extreme

A17. Lig	ht domes	tic duties (cool	king, dustin	g, etc)
O None	O Mild	O Moderate	O Severe	O Extreme

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 <u>last week</u> due to your knee.

your kne		u tillikilig of W	nat dogice c	n announcy y
SP1. Squ	ıatting			
O None	O Mild	O Moderate	O Severe	O Extreme
SP2. Ru	nning			
O None	O Mild	O Moderate	O Severe	O Extreme
SP3. Jur	nping			
O None	O Mild	O Moderate	O Severe	O Extreme
SP4. Tw	isting/piv	oting on your	injured kne	ee
O None	O Mild	O Moderate	O Severe	O Extreme
SP5. Kn	eeling			
O None	O Mild	O Moderate	O Severe	O Extreme



Prospective	Cohort
Initial Form	(Patient)

Subject ID	 		
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Quality of life:

Q1. How	often are you	aware of yo	our knee p	roblem?
O Never	O Monthly	O Weekly	O Daily	O Constantly

Q2. Have you	ur modified	your life style t	o avoid poten	tially damaging activities to your knee?
O Not at all	O Mildly	O Moderately	O Severely	O Totally

Q3. How mu	ch are you	troubled with la	ick of confide	nce in your knee?
O Not at all	O Mildly	O Moderately	O Severely	O Extremely

Q4. In general, how much difficulty do you have with your knee? O None O Mild O Moderate O Severe O Extreme

MARX SCALE

Please indicate how often you performed each activity in your healthiest and most active state, in the past year.

	Less than one time in a month 0	One time in a month	One time in a week 2	2 or 3 times in a week 3	4 or more times in a week 4
Running: while playing a sport or jogging	0	0	0	0	0
Cutting: changing directions while running	0	0	0	0	0
Deceleration: coming to a quick stop while runni	\sim	0	0	0	0
Pivoting: turning your body with your foot planted while playing sport; For example: skiin skating, kicking, throwin hitting a ball (golf, tennisquash), etc.	ng,	0	0	0	0