

## QUICK DASH FORM

# DISABILITIES OF THE ARM SHOULDER AND HAND

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** (MM/DD/YYYY) \_\_\_\_\_

**DID YOU HAVE SURGERY FOR THIS ISSUE PRIOR TO RECEIVING PHYSICAL THERAPY?**     **YES – DATE:** (MM/DD/YYYY) \_\_\_\_\_  **NO**

**DID YOU HAVE SURGERY FOR THIS ISSUE DURING THE COURSE OF RECEIVING PHYSICAL THERAPY?**     **YES – DATE:** (MM/DD/YYYY) \_\_\_\_\_  **NO**

**PAIN SCORE: OVER THE PAST 24 HOURS, HOW BAD HAS YOUR PAIN BEEN?**  
CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR PAIN.

NO PAIN    0    1    2    3    4    5    6    7    8    9    10    WORST IMAGINABLE PAIN

**PLEASE RATE YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES IN THE LAST WEEK:**  
MARK THE BOX THAT CORRESPONDS TO THE MOST APPROPRIATE RESPONSE FOR EACH ROW.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE TO DO
<b>1. OPEN A TIGHT OR NEW JAR</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. DO HEAVY HOUSEHOLD CHORES (E.G. WASH WALLS, WASH FLOOR)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. CARRY A SHOPPING BAG OR BRIEFCASE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. WASH YOUR BACK</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. USE A KNIFE TO CUT FOOD</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. RECREATIONAL ACTIVITIES IN WHICH YOU TAKE SOME FORCE OR IMPACT THROUGH THE SHOULDER, HAND OR ARM (GOLF, HAMMERING, TENNIS ETC.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**QUICK DASH FORM**  
**DISABILITIES OF THE ARM SHOULDER AND HAND**

**PLEASE RATE YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES IN THE LAST WEEK:**  
 MARK THE BOX THAT CORRESPONDS TO THE MOST APPROPRIATE RESPONSE FOR EACH QUESTION.

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
<b>7. DURING THE PAST WEEK, TO WHAT EXTENT HAS YOUR ARM, SHOULDER OR HAND PROBLEM INTERFERED WITH YOUR NORMAL SOCIAL ACTIVITIES WITH FAMILY, FRIENDS, NEIGHBORS, OR GROUPS?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
<b>8. DURING THE PAST WEEK, WERE YOU LIMITED IN YOUR WORK OF OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR ARM, SHOULDER OR HAND PROBLEM?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**RATE THE SEVERITY OF THE FOLLOWING SYMPTOMS IN THE LAST WEEK:**  
 MARK THE BOX THAT CORRESPONDS TO THE MOST APPROPRIATE RESPONSE FOR EACH ROW.

	NONE	MILD	MODERATE	SEVERE	EXTREME
<b>9. ARM, SHOULDER, OR HAND PAIN</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10. TINGLING (PINS AND NEEDLES) IN YOUR ARM, SHOULDER OR HAND</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NONE	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
<b>11. DURING THE PAST WEEK, HOW MUCH DIFFICULTY HAVE YOU HAD SLEEPING BECAUSE OF PAIN IN YOUR ARM, SHOULDER, OR HAND?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>