QUICK DASH

Patient Name: _____ Date: _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

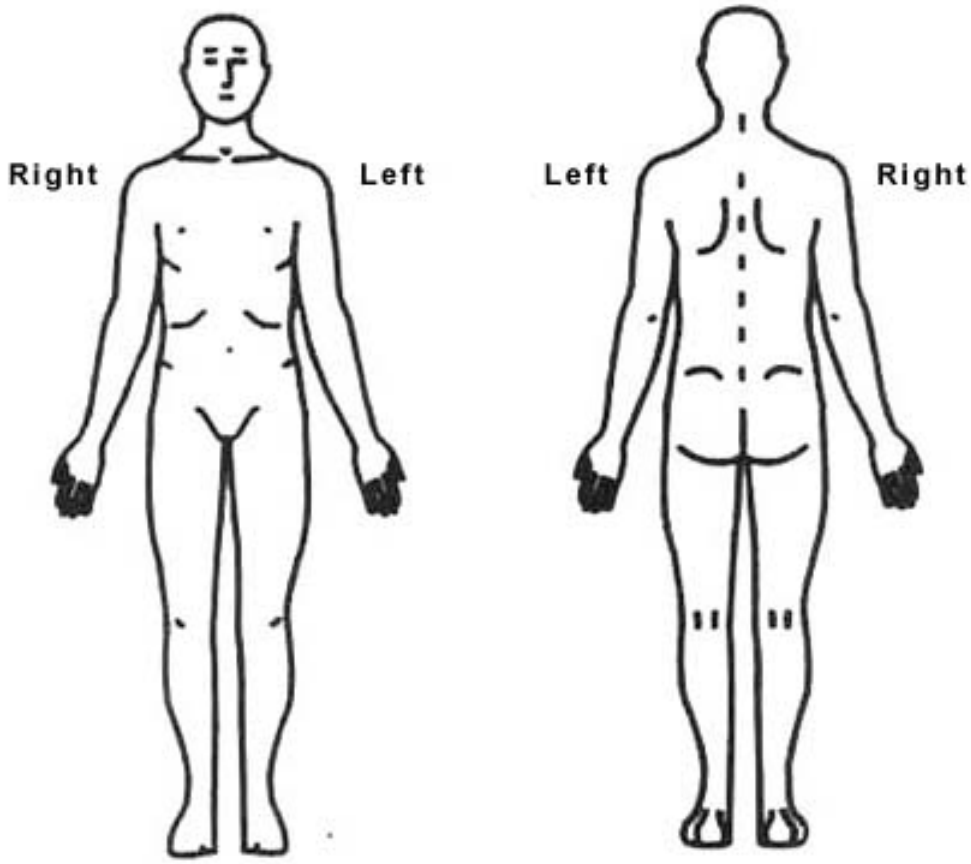
	No Difficulty	**Mild Difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**Unable**
1. Open a tight jar	1	2	3	4	5
2. Do heavy household chores (e.g. wash walls and floors)	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, tennis, hammering, etc)	1	2	3	4	5
	Not at All	**Slightly**	**Moderately**	**Quite a Bit**	**Extremely**
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.	1	2	3	4	5
	Not Limited At All	**Slightly Limited**	**Moderately Limited**	**Very Limited**	**Unable**
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem.	1	2	3	4	5
Please rate the severity of the following symptoms in the last week.	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder, or hand.	1	2	3	4	5
	No Difficulty	**Mild Difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**Can't Sleep**
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?	1	2	3	4	5

([sum of n responses/number of responses]-1) x 25. A quick dash score may not be calculated if there is greater than one missing item.

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: _____