

Patient Name: _____

Today's Date: ___/___/___

This questionnaire will give your provider information about how your upper extremity condition affects your everyday life. Please rate your ability to do the following activities by selecting the box below the appropriate response.

	NO DIFFICULTY 1	MILD DIFFICULTY 2	MODERATE DIFFICULTY 3	SEVERE DIFFICULTY 4	UNABLE 5
1. Open a tight new jar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do heavy household chores (e.g., wash walls, floors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Carry a shopping bag or briefcase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Wash your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Use a knife to cut food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Recreation activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NOT AT ALL 1	SLIGHTLY 2	MODERATELY 3	QUITE A BIT 4	EXTREMELY 5
7. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

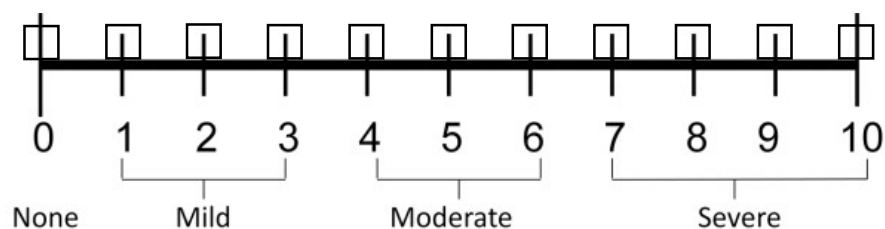
	NOT LIMITED AT ALL 1	SLIGHTLY LIMITED 2	MODERATELY LIMITED 3	VERY LIMITED 4	UNABLE 5
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please rate the severity of the following symptoms in the last week. (circle number)

	NONE 1	MILD 2	MODERATE 3	SEVERE 4	EXTREME 5
9. Arm, shoulder or hand pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tingling (pins & needles) in your arm, shoulder or hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NO DIFFICULTY 1	MILD DIFFICULTY 2	MODERATE DIFFICULTY 3	SEVERE DIFFICULTY 4	SO MUCH DIFFICULTY THAT I CAN'T SLEEP 5
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the scale below please rate from 0 (no pain) to 10 (worst imaginable) the level of pain that best reflects the pain you are experiencing with your condition.



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$$\left(\frac{\text{sum of } n \text{ responses}}{n} \right) - 1 \times 25$$

Where n is equal the number of completed responses. May not be calculated if there is greater than 1 missing response.

DASH Score = _____