Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**QuickDASH**

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

Today, do you or would you have any difficulty at all with:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **No Difficulty** | **Mild Difficulty** | **Moderate Difficulty** | **Severe Difficulty** | **Unable** |
| 1. | Open a tight or new jar | 1 | 2 | 3 | 4 | 5 |
| 2. | Do heavy chores (e.g. wash walls, 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, hammering, tennis, 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 |
|  |  | **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** | **So Much That I 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 |

= \_\_\_\_\_\_\_\_\_\_\_\_\_\_

QuickDASH Score:

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_