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
1.	OPEN A TIGHT OR NEW JAR	☐	☐	☐	☐	☐
2.	DO HEAVY HOUSEHOLD CHORES (E.G. WASH WALLS, WASH FLOOR)	☐	☐	☐	☐	☐
3.	CARRY A SHOPPING BAG OR BRIEFCASE	☐	☐	☐	☐	☐
4.	WASH YOUR BACK	☐	☐	☐	☐	☐
5.	USE A KNIFE TO CUT FOOD	☐	☐	☐	☐	☐
6.	RECREATIONAL ACTIVITIES IN WHICH YOU TAKE SOME FORCE OR IMPACT THROUGH THE SHOULDER, HAND OR ARM (GOLF, HAMMERING, TENNIS ETC.)	☐	☐	☐	☐	☐

keet health

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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
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?	☐	☐	☐	☐	☐

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
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?	☐	☐	☐	☐	☐

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
9. ARM, SHOULDER, OR HAND PAIN	☐	☐	☐	☐	☐
10. TINGLING (PINS AND NEEDLES) IN YOUR ARM, SHOULDER OR HAND	☐	☐	☐	☐	☐

	NONE	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. DURING THE PAST WEEK, HOW MUCH DIFFICULTY HAVE YOU HAD SLEEPING BECAUSE OF PAIN IN YOUR ARM, SHOULDER, OR HAND?	☐	☐	☐	☐	☐

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