

## QuickDASH – INITIAL

Please answer *every* question, based on your condition in the last week. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

1. **Opening a tight or new jar**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
2. **Do heavy household chores (eg, wash walls, floors)**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
3. **Carry a shopping bag or briefcase**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
4. **Wash your back**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
5. **Use a knife to cut food**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
6. **Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc.)**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable
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) Not at all
  - (2) Slightly
  - (3) Moderately
  - (4) Quite a bit
  - (5) Extremely
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) Not limited at all
  - (2) Slightly limited
  - (3) Moderately limited
  - (4) Very limited
  - (5) Unable
9. **Arm, shoulder or hand pain**
  - (1) None
  - (2) Mild
  - (3) Moderate
  - (4) Severe
  - (5) Extreme
10. **Tingling (pins and needles) in your arm, shoulder or hand**
  - (1) None
  - (2) Mild
  - (3) Moderate
  - (4) Severe
  - (5) Extreme
11. **During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?**
  - (1) No Difficulty
  - (2) Mild Difficulty
  - (3) Moderate Difficulty
  - (4) Severe Difficulty
  - (5) Unable

**Please rate your pain level with activity:**      0      1      2      3      4      5      6      7      8      9      10

**WHAT ARE YOUR MAJOR GOALS FOR PHYSICAL THERAPY:** \_\_\_\_\_

Physical therapy by its nature involves physical activity including, hands on treatment, exercise, stretching and other modalities. While the ultimate goal of these treatments is to reduce your pain and improve your function the implementation of these treatments may temporarily exacerbate your symptoms or soreness. Should this become intolerable you always have the right to ask for treatment to be reduced. By signing below you agree with the above activity levels, goals and understand the above statement.

**PATIENT SIGNATURE:** \_\_\_\_\_