

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

## QuickDASH

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 or new jar.   | 1             | 2               | 3                   | 4                 | 5      |
| 2. Do heavy household 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, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours 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. (*circle number*)

|  | 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 DIFFICULTY 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? ( <i>circle number</i> ) | 1             | 2               | 3                   | 4                 | 5                                     |