QUICK DASH

Name: _____ DOB: _____ Today's Date: _____

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number. 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 the most accurate.

		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 (ex. 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 (ex. golf, hammering, tennis, etc.).	1	2	3	4	5
7.	What extent has your arm, shoulder or hand problem interfered with your normal social activities (family, friends, neighbors or groups)?	1	2	3	4	5
8.	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
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
11.	How much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	1	2	3	4	5