

Patient Name:

Date Completed:

## Quick DASH

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
Open a tight or new jar	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Do heavy household chores (e.g., wash walls, floors)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Carry a shopping bag or briefcase	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wash your back	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Use a knife to cut food	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

	Not At All	Slightly	Moderately	Quite A Bit	Extremely
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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

	Not Limited At All	Slightly Limited	Moderately Limited	Very Limited	Unable
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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please rate the severity of the following symptoms in the last week. (circle number)	None	Mild	Moderate	Severe	Extreme
Arm, shoulder or hand pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tingling (pins and needles) in your arm, shoulder or hand.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much Difficulty That I Can't Sleep
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

QuickDASH Disability/Symptom Score =  $(\frac{\text{sum of n response} - 1}{n}) \times 25$ , where n is equal to the number of completed responses. A QuickDASH score may **not** be calculated if there is greater than 1 missing item.

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## Quick DASH

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

<b>WORK MODULE (OPTIONAL)</b>					
The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role.)					
Please indicate what your job/work is:					
Please circle the number that best describes your physical ability in the past week.					
Did you have any difficulty:	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Using your usual technique for your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Doing your usual work because of arm, shoulder or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Doing your work as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Spending your usual amount of time doing your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

<b>SPORTS/PERFORMING ARTS MODULE (OPTIONAL)</b>					
The following questions relate to the impact of your arm, shoulder or hand problem on playing your musical instrument or sport or both. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.					
Please indicate the sport or instrument which is most important to you:					
Please circle the number that best describes your physical ability in the past week.					
Did you have any difficulty:	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Using your usual technique for playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Playing your musical instrument or sport because of arm, shoulder or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Playing your musical instrument or sport as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Spending your usual amount of time practicing or playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**Scoring the optional modules:** Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25. An optional module score may not be calculated if there are any missing items.