QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

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.
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.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	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, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors 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
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY 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? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code:

Olympic Physical Therapy, LLC

Patient Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____

How much pain do you have <u>today?</u> Please circle a number (0= no pain, 10= worst pain)

0 1 2 3 4 5 6 7 8 9 10

Please list below any medications you are currently taking. Please include prescription meds, over the counter meds, and/or supplements with names, dosage, and frequency.

Drug Name	Dosage	Frequency	Drug name	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

Have you had an injury as a result of a fall in the past year? (Please circle one): **Yes** **No**

Have you had two or more falls in the past year? **Yes** **No**

Who is your primary care physician?_____

When is the next time you are seeing a physician?_____

Have you had any diagnostic tests for this problem? **Yes** **No** (If Yes, please list below):

_____

Have you had a specific injury or surgery for this problem? **Yes** **No** (If Yes, please list below):

_____

Please list any other medical problems you have, or any other surgeries you have had?

_____

_____

Are you currently employed? **Yes** **No** **Job Title?**_____

Has your work schedule been modified because of this problem? **Yes** **No**

Are you living alone at this time? **Yes** **No**

What goal(s) would you like to accomplish with PT? _____

Please turn page over ⟶