**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSTRUCTIONS**

This questionnaire is 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 any of these activities in the past week, please make your best estimate as to which response would be most accurate**. It does not matter which hand/arm you would normally use to perform the activity, please answer based on your ability regardless of how you perform the task.

**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 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| **Not At All** | **Slightly Limited** | **Moderately**  | **Quite A Bit** | **Unable** |
| 1 | 2 | 3 | 4 | 5 |
| **Not At All** | **Slightly Limited** | **Moderately Limited** | **Quite A Bit** | **Unable** |
| 1 | 2 | 3 | 4 | 5 |
| **None** | **Mild** | **Moderate** | **Severe** | **Extreme** |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |

1. Open a tight or new jar
2. Do heavy household chores (e.g. wash walls, floors).
3. Carry a shopping bag or briefcase
4. Wash your back
5. Use a knife to cut food
6. Recreational activities in which take

some force or impact through your arm,

shoulder or hand (e.g. golf, hammering, tennis, etc.).

1. During the past week, to which extent has

 your arm, shoulder, or hand problem interfered

 with your normal activities with family, friends,

neighbors or groups?

1. 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?

**Please rate the severity of the following symptoms in the last week.**

1. Arm, shoulder or hand pain.
2. Tingling (pins and needles) in your arm, shoulder or hand.
3. Difficulty sleeping because of the pain in your arm, shoulder or hand.

**WORK MODULE (ONLY IF INJURY INTERFERES WITH YOUR WORK)**

The following questions ask about the impact 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.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No Difficulty** | **Mild Difficulty** | **Moderate Difficulty** | **Severe Difficulty** | **Unable** |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |
| 1 | 2 | 3 | 4 | 5 |

**Did you have any difficulty:**

1. Using your usual technique for work?
2. Doing your usual work because of arm, shoulder or hand pain?
3. Doing your work as well as you would like?
4. Spending your usual amount of time doing work?

OFFICE USE ONLY:

 Add up assigned values for each response: Divide by number of questions answered: (DO NOT INCLUDE WORK MODULE) Subtract value by 1: Multiply by 25.

Work Module: Add up assigned values for each response: Divide by 4: Subtract 1: Multiply by 25.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Indicate your level of pain at the following times by placing a dash on the line that indicates where you rate your pain. The line begins with 0, indicating no pain, and ends with 10, indicating the worst pain imaginable.**

**When your pain is the lowest it can be:**

 No pain 0 10 Worst pain imaginable

**When your pain is the at its worst it can be:**

 No pain 0 10 Worst pain imaginable

**What your pain is right now:**

 No pain 0 10 Worst pain imaginable

**Please indicate the amount of improvement you have made since the beginning of your treatment:**

 None 0 10 Complete Recovery