Patient's Name_____ **Date** _____

QUICK DASH TEST

Please rate your ability to do the following in the last week by circling the number below to 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.	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.	1	2	3	4	5
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, etc?	1	2	3	4	5
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:

	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
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?	1	2	3	4	5

For Therapist Use:

Total Score _____ /(10 or 11 questions answered*) -1 x 25

(*not valid if <10)