

# DISABILITIES OF THE ARM, SHOULDER AND HAND

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

	NO DIFFICUL	MILD DIFFICUL	MODERAT E DIFFICUL	SEVERE DIFFICUL	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. 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
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another)	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

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NOT AT ALL    SLIGHTLY    MODERATELY    QUITE A BIT    EXTREMELY

22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? (*circle number*)

1                      2                      3                      4                      5

NOT AT ALL    SLIGHTLY LIMITED    MODERATELY LIMITED    VERY LIMITED

23. During the past week, were you limited in your or other regular daily activities as a result of your shoulder or hand problem? (*circle number*)

1                      2                      3                      4                      5

Please rate the severity of the following symptoms in the last week. (*circle number*)

NONE    MILD    MODERATELY SEVERE    EXTREMELY SEVERE

24. Arm, shoulder or hand pain.

1                      2                      3                      4                      5

25. Arm, shoulder or hand pain when you performed any specific activity.

1                      2                      3                      4                      5

26. Tingling (pins and needles) in your arm or hand.

27. Weakness in your arm or hand.

28. Stiffness in your arm or hand.

DIFFICULTY  
DIFFICULTY  
DIFFICULTY  
DIFFICULTY

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29. 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

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STRONGLY  
DISAGREE

DISAGREE

NEITHER AGREE  
NOR DISAGREE

STRONGLY  
AGREE

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30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem.  
(circle number)

1

2

3

4

5

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DASH DISABILITY/SYMP TOM SCORE =  $([(\text{sum of } n \text{ responses} / n) - 1] \times 25, \text{ where } n \text{ is the number of completed responses.})$

A DASH score may not be calculated if there are greater than 3 missing items.

## THE **DASH**

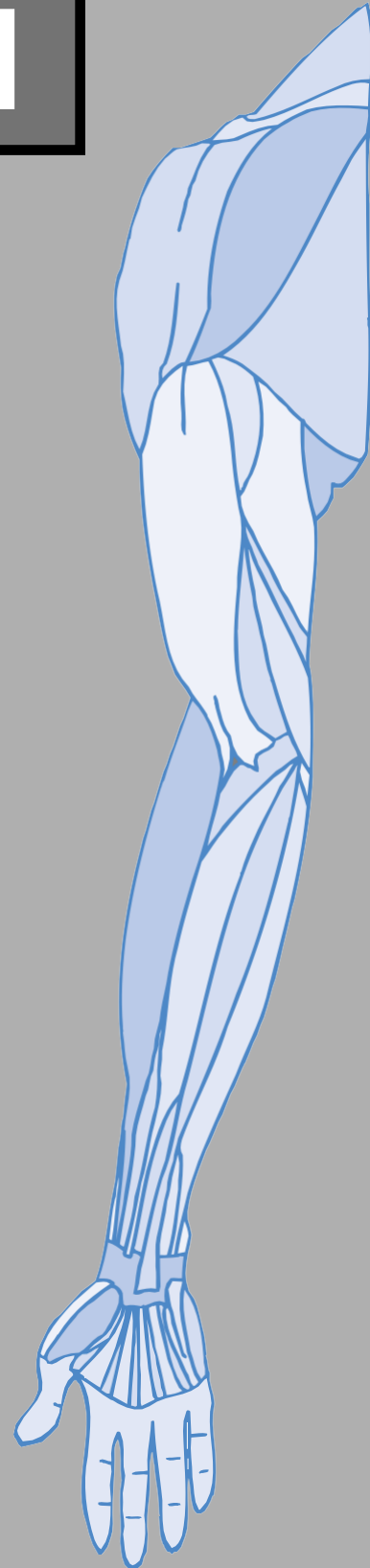
### INSTRUCTIONS

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* on 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.



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## WORK MODULE (OPTIONAL)

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: \_\_\_\_\_

I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	UNABLE NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

## SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

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: \_\_\_\_\_

I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	UNABLE NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	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.



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## SF-12 Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer.** If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

- <sub>1</sub> Excellent    <sub>2</sub> Very good    <sub>3</sub> Good    <sub>4</sub> Fair    <sub>5</sub> Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limit ed a	YES, limit ed a	NO, not limite
2. <b>Moderate activities</b> such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
3. Climbing <b>several</b> flights of stairs.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
4. <b>Accomplished less</b> than you would like.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
5. Were limited in the <b>kind</b> of work or other activities.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. <b>Accomplished less</b> than you would like.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
7. Did work or activities <b>less carefully than usual</b> .	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

8. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?

- <sub>1</sub> Not at all    <sub>2</sub> A little bit    <sub>3</sub> Moderately    <sub>4</sub> Quite a bit    <sub>5</sub> Extremely

These questions are about how you have been feeling during the past 4 weeks.

	All of the	Mo st of	A good bit of	S o m e o f	A little o f	N o n e o f
9. Have you felt calm & peaceful?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
10. Did you have a lot of energy?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
11. Have you felt down-hearted and blue?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

12. During the past 4 weeks, how much of the time has your physical health or emotional

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Patient name:

Date:

PCS:

MCS:

Visit type (circle one)

Preop

3 week

3 month

6 month

12 month

24 month

Other: