Patient Name: _____ Date: _____

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 Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	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 or 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 light bulb 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., card playing, 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

Page 1 Total Score / # or completed Responses: _____/_____

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:**_____

Patient Name: _____ Date: _____

DISABILITIES OF THE ARM, SHOULDER AND HAND

	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, neighbors or groups?	1	2	3	4	5

(CIRCLE ONE)

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. **During the past week, were you limited in your work or other regular daily activities as a result of you arm, shoulder or hand problem?**	**1**	**2**	**3**	**4**	**5**

(CIRCLE ONE)

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

	NONE	MILD	MODERATELY	SEVERE	EXTREME
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, shoulder, hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	**1**	**2**	**3**	**4**	**5**
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATELY DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. **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**

(CIRCLE ONE)

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem.	1	2	3	4	5

(CIRCLE ONE)

Page 2 Total Score / Page 2 # of Completed Responses: _____/_____

Page 1 & 2 Total Score / Page 1 & 2 Completed Responses: _____/_____

DASH DISABILITY/SYMPTOM SCORE = $\frac{[(\text{Sum of n responses}) - 1] \times 25}{n}$, where n is equal to the number of completed responses.

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

DASH Score:_____% disability

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____