

Client Name: _____ DOB: _____

Chart #:

DISABILITIES OF THE ARM, SHOULDER, AND HAND

Section One

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

ACTIVITIES	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 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. card playing, knitting)	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)	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g. playing Frisbee, badminton)	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

	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?	1	2	3	4	5
	Not limited at all	Slightly limited	Moderately limited	Very limited	Unable
23. During the past week, were you limited in your or other regular 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
24. Arm, shoulder or hand pain.	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
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 or 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	Moderate 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
	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

Section Three

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 check the box in the column that best describes your physical ability in the past week.

ACTIVITIES	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. using your usual techniques for playing your instrument or sport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. playing your musical instrument or sport as well as you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. spending your usual amount of time practicing or playing your instrument or sport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 check the box in the column that best describes your physical ability in the past week.

ACTIVITIES	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. using your usual techniques for work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. doing your usual work because of arm, shoulder or hand pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. doing your work as well as you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. spending your usual amount of time doing your work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date: _____

Signed: _____

Scored by: _____