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, 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

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, neighbours or groups? *(circle number)*	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 work or other regular daily activities as a result of your arm, 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	MODERATE	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 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? *(circle number)*	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. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

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

DISABILITIES OF THE ARM, SHOULDER AND HAND

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:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
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:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
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 <u>not</u> be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

AAOS COMSS

MEDICAL HISTORY FORM

1. Name

Last	First	MI

2. Are you: ☐ Right-handed ☐ Left-handed

3. Employment

☐ Work outside of home ☐ Student
☐ Homemaker ☐ Retired
☐ Unemployed

Occupation: _____

How many hours do you spend in computer/desk work per day?_____

How much and how often do you lift objects heavier than 10 pounds?

# of times/day: _____
Average weight of objects lifted: _____

4. Where do you live?

☐ Private home ☐ Private apartment
☐ Board & care / assisted living / group home
☐ Other _____

5. With whom do you live?

☐ Alone ☐ Spouse
☐ Child ☐ Other relative
☐ Pets ☐ Other _____
☐ Personal care attendant
☐ 24-hour ☐ Part-time

6. Does your home have:

☐ Stairs ☐ Ramps
☐ Elevator

7. Do you use:

☐ Cane ☐ Walker ☐ Other _____

8. Do you have any vision or hearing problems? ☐ Yes ☐ No

Do you use:

☐ Glasses/Contacts ☐ Hearing Aid

9. Medications

Do you currently take any prescription medications?

☐ Yes ☐ No If yes, please list: _____

_____

_____

_____

Do you currently take any nonprescription medications?

☐ Antacids ☐ Ibuprofen/ Naproxen
☐ Antihistamines
☐ Aspirin ☐ Laxatives
☐ Decongestants ☐ Tylenol
☐ Herbal supplement ☐ Vitamins

Other _____

10. Health Habits

Please rate your health:

☐ Excellent ☐ Good
☐ Fair ☐ Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

☐ Yes

Please describe the exercise, sport or hobby: _____

_____

_____

How many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

☐ No

Do you currently use or have you previously used tobacco?

☐ Yes Cigarettes, # of packs/day _____
Cigars, # per day _____
Chewing tobacco_____
Year quit: _____

☐ No

How many days per week do you drink beer, wine, or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day? _____

Do you have a history of chemical dependency?

☐ Yes ☐ No

11. Within the past year, have you had any of the following medical tests?

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Pulmonary function test
☐ Stress test (such as treadmill, bicycle)
☐ X-rays

Therapist comments: _____

_____

_____

_____

Therapist signature: _____

CONTINUE ON OTHER SIDE

12. Medical History

Please check if you have had:	Yes	No
Allergies		
Arthritis		
Bladder problems (including repeated infections, urinary incontinence, leaking)		
Blood disorders (including hemophilia/anemia)		
Bone/joint infections		
Broken bones/fractures		
Cancer		
Circulation/vascular		
Depression		
Developmental or growth problems		
Diabetes or problems with blood sugar		
Fibromyalgia		
Head injury		
Heart problems (Pacemaker)		
High blood pressure		
Infectious diseases (such as tuberculosis, hepatitis, HIV)		
Kidney problems		
Liver problems		
Lung problems (including asthma)		
Metal implants		
Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)		
Osteoporosis		
Seizures/epilepsy		
Sensitivity to latex rubber		
Skin diseases		
Thyroid problems		
Ulcers/stomach problems		
Other: _____		

For men:

Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No

For women:

Have you ever been diagnosed with:

☐ Pelvic inflammatory disease? ☐ Endometriosis? ☐ Trouble with your period?

☐ Complicated pregnancies/deliveries?

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

13. Have you ever had surgery?

☐ Yes ☐ No

If yes, please describe and include dates: ____

_____

_____

_____

14. Within the past year, have you had any of the following symptoms?

☐ Bowel problems
☐ Chest pain
☐ Coordination problems
☐ Chronic cough
☐ Difficulty sleeping
☐ Dizziness or blackouts
☐ Fever/chills/ sweats
☐ General malaise
☐ Headaches
☐ Hearing problems
☐ Heart palpitations
☐ Hoarseness
☐ Loss of appetite
☐ Loss of balance or falls
☐ Nausea/ vomiting
☐ Pain during the night
☐ Sexual dysfunction
☐ Shortness of breath
☐ Urinary problems or change in frequency
☐ Vision problems
☐ Weakness in arms or legs
☐ Weight loss/gain

15. Are you currently seeing anyone else for this diagnosis?

☐ Acupuncturist
☐ Athletic trainer
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family doctor
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/ gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other _____

If you see another health professional for this problem, may the physical therapist discuss your case with him or her? ☐ Yes ☐ No

Patient Signature: _____

Date: ____/____/____

Therapist comments: _____

_____

_____

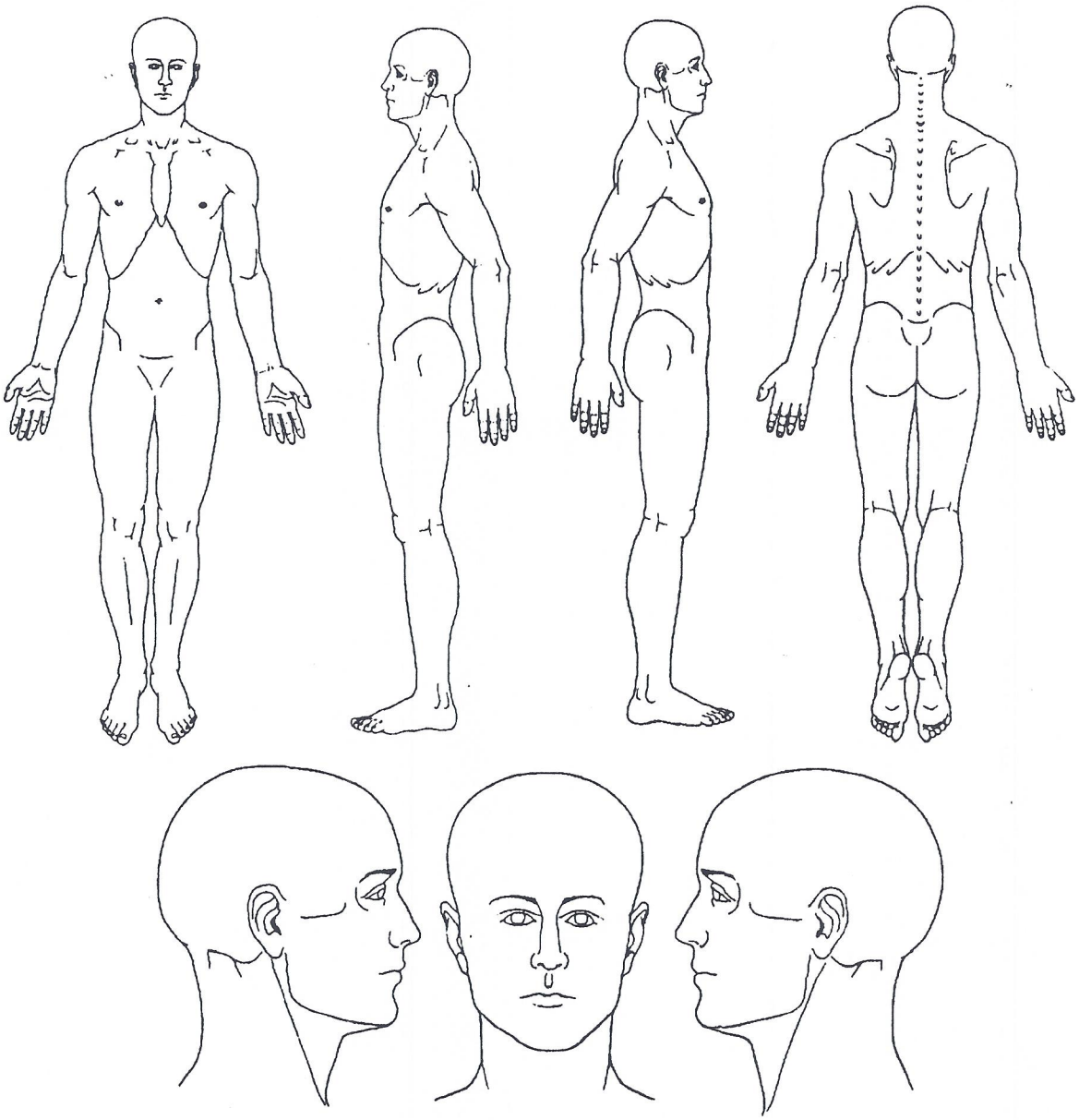
_____

Therapist signature: _____

Pain Assessment Form

Pain Diagram

At this time, where is your pain?
Please mark on the drawings the area where you feel pain (circle or mark with crosses)



PAIN RATING (On scale of 0 to 10, with 10 the worst)

Current:

Best:

Worst: