

THE **Quick DASH**  
OUTCOME MEASURE

**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* of 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.

**Please Print:**

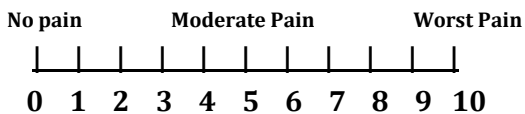
Last, First Name:

Date:

A. What is the primary problem/complaint?

B. When did your problem arise?

C. Please indicate your pain level (circle one of the bars) on the following numerical scale (0=no pain; 10- worst possible pain):



D. Location of your problem?

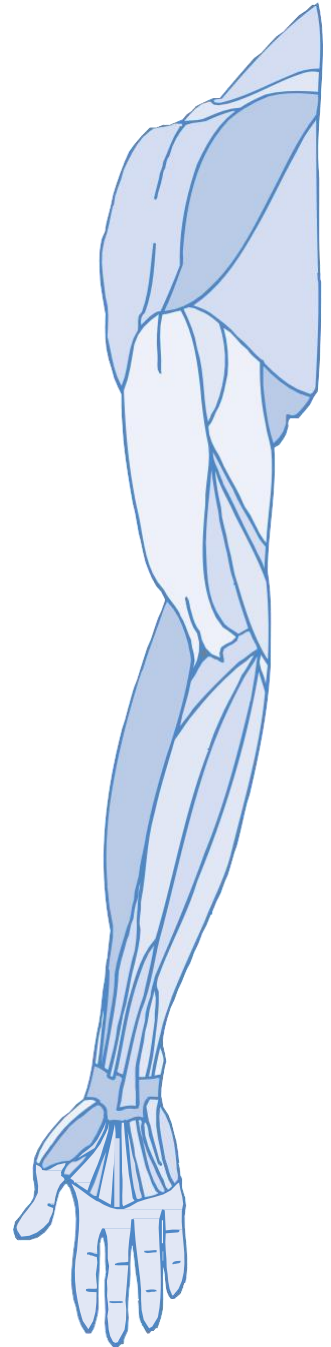
E. What is the quality of your pain? (Please circle)

Sharp	Burning	Tender	Numb	Tingling	Pulling
Dull	Crushing	Throbbing	Tiring	Stabbing	Aching

F. For how long have you experienced these problems?

G. What makes symptoms worse?

H. What makes the symptoms go away or feel better?



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. Do heavy household chores (e.g., wash walls floors.)	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. (e. g., golf, hammering, tennis, etc.)	1	2	3	4	5

	Not At All	Slightly	Moderately	Quite A Bit	Extremely
7. 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

	Not Limited At All	Slightly Limited	Moderately Limited	Very Limited	Unable
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. (circle number)

	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

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much Difficulty That I Can't Sleep
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, should or hand (circle one)	1	2	3	4	5

For Office Use Only: QuickDash/Symptom Score = ( [Sum of n responses/n] -1) X 25, where n is equal to number of completed responses. A Quick Dash score may NOT be calculated if there is greater than 1 missing item.