In Motion Physical Therapy – Disabilities of the Arm, Shoulder and Hand

Patient Name: _____ Date: _____

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 wall, 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 brief case	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)	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	1	2	3	4	5
21. Social activities	1	2	3	4	5

COMPLETE OTHER SIDE → → →

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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, neighbors 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 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:					
	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?	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
Column Totals:					

Patient Signature: _____ Therapist Signature: _____