QuickDASH - Initial Patient name:_____ Date:_____

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.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	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
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. 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

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

Initial Intake Questionnaire

Body part being seen for:_____

Weight:_____ Height:_____

Date of injury:____/____/_____ Date of Surgery:_____/_____/____

Did your symptoms come on as a:

- Gradual process
- New Injury
- Chronic problem

Occupation:

Is the work load:

- Sedentary
- Light
- Medium
- Heavy

Primary concern/complaint:

What is your goal to achieve from physical therapy?

Pain rating: 0=No pain and 10=Severe, unrelenting pain that makes you unable to function at all

Worst (when you have the most pain): 0 1 2 3 4 5 6 7 8 9 10

Current (what it is now): 0 1 2 3 4 5 6 7 8 9 10

Best (when you have the least pain): 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (Circle all that apply): Dull/Achy Sharp Throbbing Burning Shooting

Constant Intermittent

Medications (Please list or provide a list):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I have provided my medication list to the best of my knowledge and will notify my therapist of any changes as they occur.

Signature:_____ Date:____/_____/_____

Past Medical History: Check all that apply

○ Alzheimer's ○ Cardiovascular Disease ○ Stroke ○ Current Infection ○ Diabetes Mellitus Type 1 ○ Diabetes Mellitus Type 2 ○ Fibromyalgia ○ Fracture Or Suspected Fracture ○ High Blood Pressure ○ Pacemaker ○ Other (Please describe below)	○ History Of Cancer (Describe below) __In Remission __Active ○ Huntington's ○ Immunosuppression ○ Lupus ○ Muscular Dystrophy ○ Obesity ○ Osteoarthritis ○ Parkinson's ○ Rheumatoid Arthritis ○ Traumatic Brain Injury ○ Infectious Disease (Describe below)

Other: _____

_____

_____

Only for patients being seen for **Low Back Pain**:
Have you experienced any of the following symptoms?

- ○ Saddle Numbness (numbness in the groin region)
- ○ Problems with urination: (circle all that apply) Incontinence Urgency Can't go
- ○ Problems with bowel: (circle all that apply) Can't control Can't go

Email: _____

(This is optional, however by providing your email it will allow us to communicate issues regarding your account, updates about our company and allow you an opportunity for online bill pay. We will not share your email with any outside agency except our contracted billing agency, LB Medical Billing, LLC)

How did you hear about us? _____