



The Disabilities of the Arm, Shoulder and Hand Score (QuickDash)

Please fill in your details below:

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. If you did not have opportunity to perform an activity in the past week, please make your best estimate on 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.

	0	2-3	4-5	6-8	9-10
1. Open a tight or new jar					
2. Do heavy household chores (eg. wash walls, wash floors)					
3. Carry a shopping bag or briefcase					
4. Wash your back					
5. Use a knife to cut food					
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg. golf, hammering, tennis, etc...)					

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your work with family, friends, neighbors or groups?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Slightly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Quite a bit	<input type="checkbox"/> Extremely
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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?	<input type="checkbox"/> Not limited at all	<input type="checkbox"/> Slightly limited	<input type="checkbox"/> Moderately limited	<input type="checkbox"/> Very limited	<input type="checkbox"/> Unable
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Please rate the severity of the following symptoms in the last week					
9. Arm, shoulder or hand pain	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
10. Tingling (pins and needles) in your arm, shoulder or hand	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Mild difficulty	<input type="checkbox"/> Moderate difficulty	<input type="checkbox"/> Severe	<input type="checkbox"/> So much difficulty I can't sleep

Reference:

Hudak PL, Amadio PC, Bombardier C. Development of an upper extremity outcome measure: the DASH (disabilities of the arm, shoulder and hand) [corrected]. The Upper Extremity Collaborative Group (UECG) Am J Ind Med. 1996 Jun;29(6):602»8. Erratum in: Am J Ind Med 1996 Sep;30(3):372.

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