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

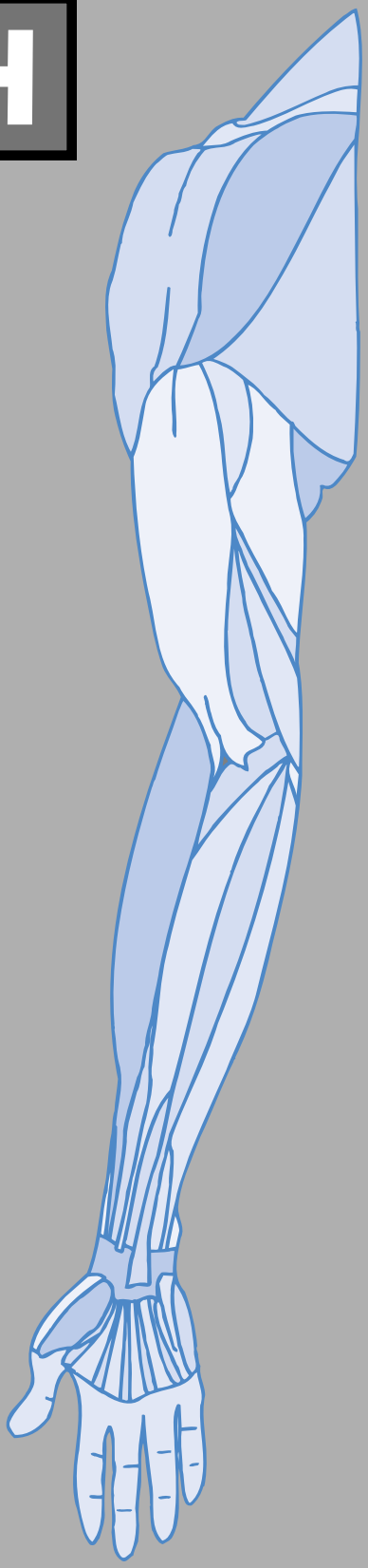
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	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.

THE DASH



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* 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.

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

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REHABILITATION

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Therapy Attendance Agreement

Welcome to Outpatient Physical Therapy at University of Maryland Charles Regional Rehabilitation. Our goal is to provide you with the best therapy services to reach your maximum potential and to improve your quality of life. We would like to inform you of our therapy attendance policy to ensure that you are getting the treatment that you need and other patients are not missing out on possible therapy times that they could have received.

Please read through and initial on the line that you have read and understand each statement:

____ CALL TO CANCEL OR RESCHEDULE. If you miss one therapy appointment without calling or cancelling at least 24 hours prior, you will be charged a $25 no show fee.

____ATTEND ALL YOUR APPOINTMENTS. If you miss three (3) consecutive therapy sessions and do not call, you will be discharged from therapy at the discretion of the therapist.

____ BE ON TIME. If you are more than 10 minutes late to a 30 minute appointment, it is up to the treating therapist if you will be seen that day.

____ If you have multiple cancellations, instances of tardiness, or missed appointments, it is up to the discretion of the primary therapist to discharge you from therapy.

All scheduling is on a first come, first served basis. We understand that both your schedule and our schedule can change and we will do our best to accommodate any changes that arise. Please inform us if you would like a copy of this form or if you have any questions about our appointment policy stated above.

Please sign that you understand and agree to the above policy:

_____ (Patient/Guardian) _____ (Date & Time)

_____ (UM CRR Staff member) _____ (Date & Time)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Please answer all questions to the best of your knowledge

Do you have any known allergies (drugs, food, pollens, latex etc): _____

Have you had any falls in the last 12 months (please circle)? **Yes** **No**

How many falls? _____ Did any fall result in injury? **Yes** **No**

Have you had any near falls? **Yes** **No** How many in the last 12 months? _____

How do you learn best (please circle): **Reading** **Demonstration** **Pictures** **Listening**

Do you feel safe in your home (please circle)? **Yes** **No**

Are you being threatened or hurt by someone (please circle)? **Yes** **No**

Over the past 2 weeks, how often have you been bothered by any of the following problems (please circle)?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

What is your preferred language? _____

Which language do you want to use while you are receiving services here? _____

Do you have, or have you had, any of the following?

- ☐ Aids/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, Bronchitis, COPD, or Emphysema
- ☐ Cancer
- ☐ Cardiac History (Angina, Congenital Heart Disorder, Heart Attack, Pace Maker, Defibrillator, Palpitations, Irregular Heartbeat, Other)
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness or Vertigo
- ☐ Edema
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Frequent Cough
- ☐ Gout
- ☐ Headaches or Migraines
- ☐ Hearing Difficulties or Ringing in your ears
- ☐ Hepatitis A, B or C
- ☐ High/Low Blood pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Loss or Cognitive Problems
- ☐ Nausea/Vomiting
- ☐ Orthopedic History
- ☐ Osteoporosis
- ☐ Pain
- ☐ Pregnant or Nursing
- ☐ Recent Weight loss
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Abnormalities
- ☐ Sleeping Difficulties
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vision Problems (Galucoma, Cataracts, Macular Degeneration, etc)
- ☐ Other _____

Comments and details regarding above history (surgeries and medication on next page): _____

Has the patient OR a sick close contact had international travel with in the last 30 days? **Yes** **No**

Where was the travel to and on what dates? _____

Does the patient currently have a fever OR flu-like symptoms? **Yes** **No**

(Symptoms include headache, aches, vomiting, abdominal pain, diarrhea, chills, etc)

University of Maryland
Charles Regional Medical Center
LaPlata, Maryland 20646

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE

PATIENT LABEL

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Major Surgeries	Date	Current Medication	Dosage	Frequency
(Please ask for surgery/medication form if more space is needed)				

Therapist Review – Office Use only

Have you previously participated in physical/occupational/speech therapy? **Yes No**

Have you had therapy services this calendar year? **Yes No**

Were you treated for your current diagnosis or another diagnosis? **Current Different**

Have you had any recent imaging performed (please circle)?

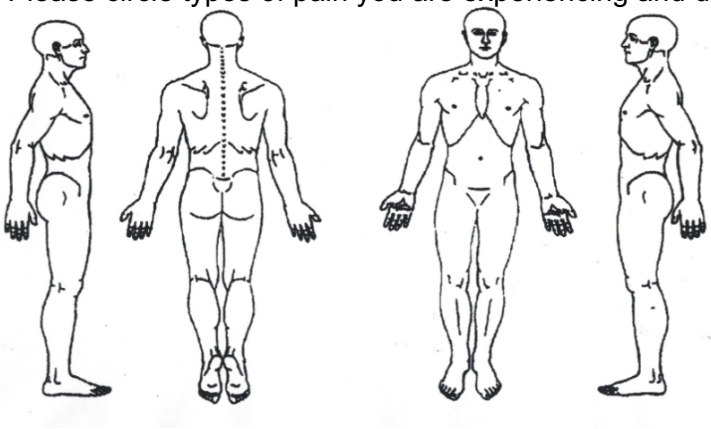
X-ray CT scan MRI EMG Modified Barium Swallow Other

Do you have any restrictions from activity from your doctor? **Yes No**

If yes, please explain: _____

What are your goals for therapy? _____

Please circle types of pain you are experiencing and draw or shade in areas of pain on the diagram:



Aching	**Burning**	**Cramping**
Dull	**Numbness**	**Pins & Needles**
Radiating	**Sharp**	**Shock Like**
Spasm	**Squeezing**	**Stabbing**
Throbbing	**Tightness**	**Tingling**
Tiring	**Other: Please explain**	_____

Advanced Directives: ☐ Durable Power of Attorney ☐ Living Will ☐ Organ Donor ☐ DNR ☐ N/A

Patients Name (Please write legibly): _____

Signature of Patient: _____ Date:_____

Signature of Caregiver (if under 18 or assisting in filling out form): _____

Signature of Therapist: _____ Date:_____

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RS-027 (0816)

PATIENT LABEL

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE