Central Jersey
Physical Therapy

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Upper Extremity Pain Questionnaire

PATIENT NAME: _____

ID#: _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability.

Please circle the answers below that best apply and rate your pain level with activity:

NO PAIN = **0 1 2 3 4 5 6 7 8 9 10** = VERY SEVERE PAIN

QUICK DASH

	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	**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?	1	2	3	4	5