

Name: _____

Please rate your ability to do the following activities in the last week by **CIRCLING** the box most appropriate to you. Please just **CIRCLE ONE BOX** that most closely describes your problem.

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|--|--------------------|------------------|---------------------|-------------------|----------------------------|
| 1. Open a tight or new jar | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 2. Do heavy chores (e.g. wash walls, floors) | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 3. Carry a shopping bag or briefcase | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 4. Wash your back | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 5. Use a knife to cut food | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 6. Recreational activity in which you take some force or impact through your arm, shoulder or hand (e.g. golf, hammering, tennis, etc.) | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
| 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? | Not At All | Slightly | Moderately | Quite A Bit | Extremely |
| 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? | Not Limited At All | Slightly Limited | Moderately Limited | Very Limited | Unable |
| 9. Severity of arm, shoulder or hand pain | None | Mild | Moderate | Severe | Extreme |
| 10. Tingling (pins and needles) in your arm, shoulder or hand | None | Mild | Moderate | Severe | Extreme |
| 11. During the past week, how much difficulty have you had sleeping because of the pain in your arm shoulder or hand? | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | So Much That I Can't Sleep |