Name: ________________________________ Date: ________________________

The UCLA Shoulder Rating Scale

INSTRUCTIONS:

Please answer the following questions by choosing one option for each section regarding your shoulder during the **past 4 weeks**:

Pain:	**Function:**
○ Present always and unbearable; strong medication used frequently	○ Unable to use limb
○ Present always but bearable; strong medication used occasionally	○ Only light activities possible
○ None or little at rest; pain present during light activities; Aspirin used frequently	○ Able to do light housework or most activities of daily living
○ Present during heavy or particular activities only; Aspirin used occasionally	○ Most housework, shopping, and driving possible; able to do hair and to dress and undress (including fastening a bra)
○ Occasional and slight	○ Slight restriction only; able to work above shoulder level
○ None	○ Normal Activities

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

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 the opportunity to perform an activity in the past week, please make sure your **best estimate** on which response would be 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.

Please rate your ability to do the following activities in the **last week.**

	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
Opening a tight or new jar	○	○	○	○	○
Writing	○	○	○	○	○
Turning a key	○	○	○	○	○
Preparing a meal	○	○	○	○	○
Pushing a heavy door	○	○	○	○	○
Placing an object on a shelf above your head	○	○	○	○	○
Doing heavy household chores	○	○	○	○	○
Gardening or doing yard work	○	○	○	○	○
Making a bed	○	○	○	○	○
Carrying a shopping bag or briefcase	○	○	○	○	○
Carrying a heavy object (over 10 lbs)	○	○	○	○	○
Changing a light bulb overhead	○	○	○	○	○
Washing or blow-drying your hair	○	○	○	○	○
Washing your back	○	○	○	○	○
Putting on a pullover sweater	○	○	○	○	○
Using a knife to cut food	○	○	○	○	○
Recreational activities that require little effort (card playing, knitting, etc.)	○	○	○	○	○
Recreational activities in which you take some force or impact through your arm, shoulder, or hand (gold, tennis, etc.)	○	○	○	○	○

Please rate your ability to do the following activities in the **last week.**

	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
Recreational activities in which you move your arm freely (badminton, frisbee, etc.)	○	○	○	○	○
Manage transportation needs (getting from one place to another)	○	○	○	○	○
Sexual activities	○	○	○	○	○
During the last 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** ○	**Slight** ○	**Moderate** ○	**A lot** ○	**Extreme** ○
During the last week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem?	**Not limited** ○	**Slightly limited** ○	**Moderately limited** ○	**Very limited** ○	**Unable** ○

Please rate your ability to do the following activities in the **last week.**

	None	**Mild**	**Moderate**	**Severe**	**Extreme**
Arm, shoulder or hand pain	○	○	○	○	○
Arm, shoulder or hand pain when you performed an specific activity	○	○	○	○	○
Tingling (pins and needles) in your arm, shoulder or hand	○	○	○	○	○
Weakness in your arm, shoulder or hand	○	○	○	○	○
Stiffness in your arm, shoulder or hand	○	○	○	○	○
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** ○	**I can't sleep** ○
I feel less capable, less confident, or less useful because of my arm, shoulder or hand problem	**Strongly disagree** ○	**Disagree** ○	**Neither agree or disagree** ○	**Agree** ○	**Strongly agree** ○

OPTIONAL SECTION:

The following questions ask about the impact on your arm, shoulder, or hand problem on your ability to work (including homemaking if that is your main role).

Do you work?

○ Yes — Please indicate what your job/work is:

○ No ____
(you may skip this section)

Please rate your ability to do the following activities in the **last week.** Did you have any difficulty…

	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
Using your usual technique for work?	○	○	○	○	○
Doing your usual work because of arm, shoulder, or hand pain?	○	○	○	○	○
Doing your work as well as you would like?	○	○	○	○	○
Spending your usual amount of time doing your work?	○	○	○	○	○

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 then one sport or instrument, please answer with respect to that activity which is most important to you.

Do you play a sport or musical instrument?

○ Yes — Please indicate which sport or instrument is most important to you:

○ No ____
(you may skip this section)

Select which best describes your physical ability in the **last week.** Did you have any difficulty…

	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
Using your usual technique for playing your instrument/sport?	○	○	○	○	○
Playing your instrument/sport because of your arm, shoulder, or hand pain?	○	○	○	○	○
Playing your instrument/sport as well as you like?	○	○	○	○	○
Spending your usual amount of time practicing or playing your instrument/sport?	○	○	○	○	○

Date: ___________________________ Date of Injury: ____________________

Patient: _________________________ Place of Injury: ___________________

Provider: ________________________ Work Related? _____ Yes / ______ No

Account #: ______________________ Auto Accident: _____ Yes / ______ No

Insurance: _______________________ ID: _____________________________

Subscriber: _____________________

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

______I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / ______ No

What did you injure? (example: left arm) _____________________________

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including <u>how</u> and <u>where</u> it occurred as required by your insurance:
____

____

____

Signature ____ Witnessed _________________________

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