

FOTO Patient Intake Survey Shoulder

Staff to Complete

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____ / ____ / ____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Date of Survey: ____ / ____ / ____

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, how much difficulty do you or would you have...	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. Combing or brushing hair using your affected arm?					
2. Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full water glass?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across to the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting deodorant under the arm opposite your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

11. Rate the level of pain you have had in the last 24 hours (please circle response):

0 1 2 3 4 5 6 7 8 9 10
 (None) (Pain as bad as it can be)

12. Please indicate the number of surgeries for your primary condition. None 1 2 3 4+
13. How many days ago did the condition begin? 0-7 days 8-14 15-21 22-90 91 days to 6 mos. ago Over 6 mos. ago
14. Are you taking prescription medication for this condition? Yes No
15. Have you received treatments for this condition before? Yes No

16. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

At least 3 times a week Once or twice per week Seldom or never

17. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Previous accidents |
| <input type="checkbox"/> Congestive heart failure (or heart disease) | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart attack (Myocardial infarction) | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anxiety or Panic Disorders |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Other disorders |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis / AIDS |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Prior surgery |
| <input type="checkbox"/> Diabetes Types I and II | <input type="checkbox"/> Prosthesis / Implants |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Sleep dysfunction |
| | <input type="checkbox"/> Cancer |

18. Height: _____ ft. _____ in. Weight: _____ lbs.

19. This is a statement other patients have made.

"I should not do physical activities which (might) make my pain worse."

Please rate your level of agreement with this statement.

- Completely Disagree
 Somewhat Disagree
 Unsure
 Somewhat Agree
 Completely Agree

THE

QuickDASH

OUTCOME MEASURE

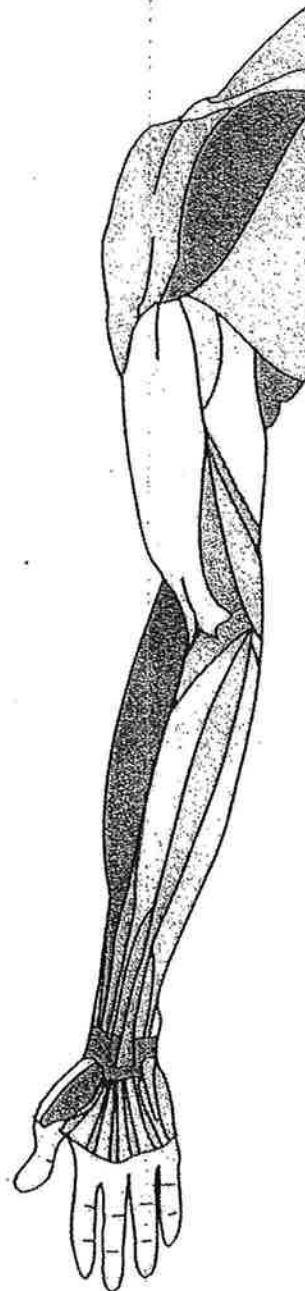
INSTRUCTIONS

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* of 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.



QuickDASH

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
Open a tight or new jar.	1	2	3	4	5
Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
Carry a shopping bag or briefcase.	1	2	3	4	5
Wash your back.	1	2	3	4	5
Use a knife to cut food.	1	2	3	4	5
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
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?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
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. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
Arm, shoulder or hand pain.	1	2	3	4	5
Tingling (pins and needles) 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
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

DASH DISABILITY/SYMPTOM SCORE = $\left(\frac{\text{sum of } n \text{ responses}}{n} - 1 \right) \times 25$, where n is equal to the number of completed responses.

QuickDASH score may not be calculated if there is greater than 1 missing item.

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 not be calculated if there are any missing items.