For Office Use Only
Chart Number:____________
Reviewed by:____________

SPECTRUM MEDICAL PHYSICAL THERAPY
PAIN & SYMPTOMS QUESTIONNAIRE

Name: ___________________________________ Age:___ Date:______ Email:__________________________

What is your present condition and/or mechanism of injury? ____
____

What is your primary concern or chief complaint? ____
____

How would you describe your pain? ____

What makes the pain worse? ____
____

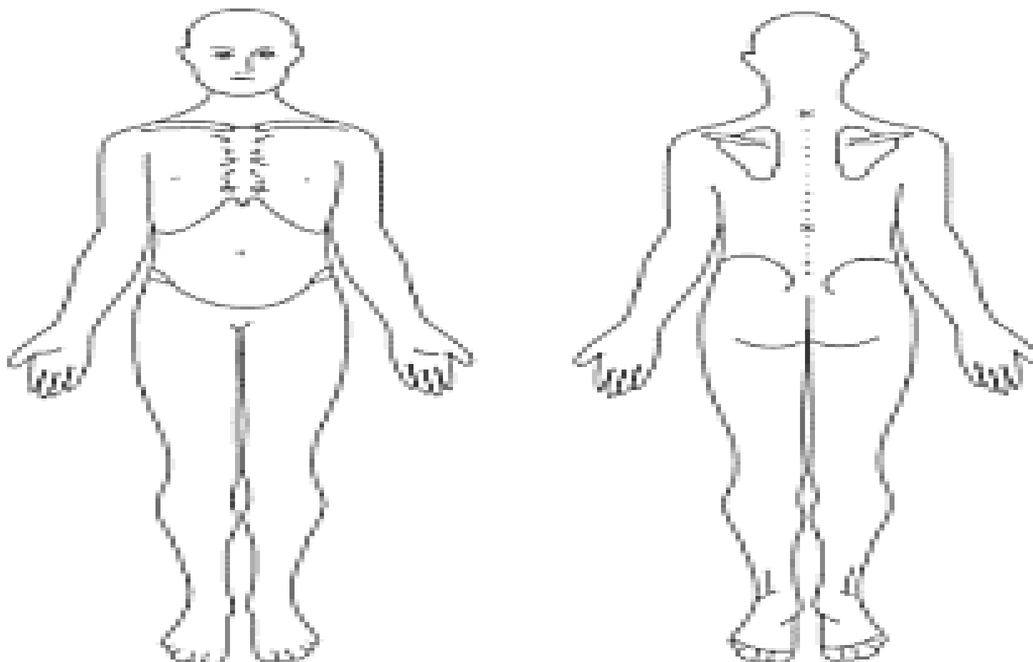
What eases your pain? ____
____

Rate the pain of your primary concern on the following scale by circling the number that best corresponds.

0 = None 5 = Moderate 10 = Extreme

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Indicate where your pain is located and what type of pain you feel at the present time.



Please check **all** that apply to your medical history:

- ❏ Osteoarthritis
- ❏ Cardiovascular Disease
- ❏ Diabetes Mellitus Type 1
- ❏ Diabetes Mellitus Type 2
- ❏ Allergies
- ❏ Complication Factors
- ❏ Surgical History
- ❏ Previous Physical Therapy for this concern
- ❏ Psycho-Social
- ❏ History of Cancer
- ❏ Current Infection
- ❏ Immunosuppression
- ❏ Fracture or Suspected Fracture
- ❏ Cauda Equina Syndrome
- ❏ Diagnostic Testing (MRI, X-Ray, etc)
- ❏

If you checked any of the above boxes, please explain. ____
____
____
____

How would you rate your overall general health? (Circle the **one** that applies best.)

Good Fair Poor

Please state your goal of physical therapy: ____
____

By signing below, I consent to a physical therapy evaluation and treatment.

Patient Signature: ____ Date: ________

SPECTRUM MEDICAL

PATIENT NAME:____ CHART#:__________________ DATE:______________

Disabilities of the Arm, Shoulder, and Hand Questionnaire (QuickDASH)

Instructions: Please rate your ability to do the following activities in the last week by checking the area below the appropriate response. Please Circle Only One.

1. Open a tight or new jar?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

2. Do heavy household chores (e.g., wash walls, floors)?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

3. Carry a shopping bag or suitcase?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

4.Wash your back?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

5. Use a knife to cut your food?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.)?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty** (4) **Unable**(5)

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(1) **Slightly**(2) **Moderately**(3) **Quite a Bit**(4) **Extremely**(5)

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 problems?
Not Limited at all(1) **Slightly Limited**(2) **Moderately Limited**(3) **Very Limited**(4) **Unable**(5)

Please rate the severity of the following symptoms in the last week.

9. Arm, shoulder or hand pain
None (1) **Mild**(2) **Moderate**(3) **Severe** (4) **Unable**(5)

10. Tingling (pins and needle) in your arm, shoulder or hand?
None (1) **Mild**(2) **Moderate**(3) **Severe** (4) **Unable**(5)

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?
No Difficulty(1) **Mild Difficulty**(2) **Moderate Difficulty**(3) **Severe Difficulty**(4) **So Much Diff., I Can't Sleep** (5)

Complete one of the following Modules depending on your situation. Please check box that best describes your physical ability in the past week. Did you have any difficulty:

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 is your job/work is: _________________________** ○ **I do not work. (You may skip this section)**	**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

Patient Initials: _______________________