GILBERT PHYSICAL THERAPY

Affiliate of OPTN

Shoulder, Elbow, Wrist, Hand

Upper Extremity Questionnaire

Patient Name: ______________________________ D.O.B.______________ Date: ________________

ACTIVITIES 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
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. Use a knife to cut food.	1	2	3	4	5
5. Wash your back.	1	2	3	4	5
6. Recreation 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
7. During the past week, how much difficulty have you had sleeping because of pain in your arm, shoulder or hand?	1	2	3	4	5
8. 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 Limited 2	Moderately Limited 3	Quite a bit 4	Extremely Limited 5
9. 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 at All 1	Slightly Limited 2	Moderately Limited 3	Quite a bit 4	Extremely Limited 5
10. Rate the severity of your arm, shoulder or hand pain.	None 1	Mild 2	Moderate 3	Severe 4	Extreme 5
11. Rate the severity of tingling (pins and needles) in your arm, shoulder or hand.	None 1	Mild 2	Moderate 3	Severe 4	Extreme 5