

# Patient Specific Functional and Pain Scales (PSFS)

Name:

Date:

**Clinician Instructions:** Have patient complete after the history and before the exam

**Initial Assessment:**

We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem. Please list and score at least 3 activities that you are unable to perform, or are having the most difficulty performing, because of your chief problem

**Follow Up Assessment:**

When you were assessed on \_\_\_\_\_, you told us you had difficulty with the activities in the table below. Please score these activities that you told us previously you were unable to perform or were having difficulty performing because of your chief problem.

**Scoring:** Please score one number for each activity and for each date in the table below:

Unable to Perform Activity

0

1

2

3

4

5

6

7

8

Able to Perform Activity At Same Level As Before Injury/Problem

9

10

Activity	Date:	Date:	Date:	Date:	Date:
1.	<u>Score (0-10)</u>				
2.	<u>Score (0-10)</u>				
3.	<u>Score (0-10)</u>				
4.	<u>Score (0-10)</u>				
5.	<u>Score (0-10)</u>				
<b>Totals:</b>					

# Functional Activity Back Questionnaire (FABQ)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**FABQ-PA Physical Activity:**

Here are some of the things that other patients have told us about their pain. For each statement, please circle any number from 0-6 to say how much physical activities, such as bending lifting, walking, or driving affect, or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6
3. Physical activity might harm my back	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

**FABQ-Work:**

The following statements are about how your normal work affects or would affect your back.

	Completely Disagree			Unsure			Completely Agree
6. My pain was caused by my work or an accident at work.	0	1	2	3	4	5	6
7. My work aggravated my pain.	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6
9. My work is too heavy for me.	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6
11. My work might harm my back	0	1	2	3	4	5	6
12. I should not do my regular work with my present pain.	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15. I do not think I will be back to my normal work within 3 months	0	1	2	3	4	5	6
16. I do not think that I will ever be able to do my normal work.	0	1	2	3	4	5	6

SCORE: FABQ-PA \_\_\_\_\_ FABQ-Work\_\_\_\_\_

# The Keele STarT Back Screening Tool

Name: \_\_\_\_\_

Date: \_\_\_\_\_

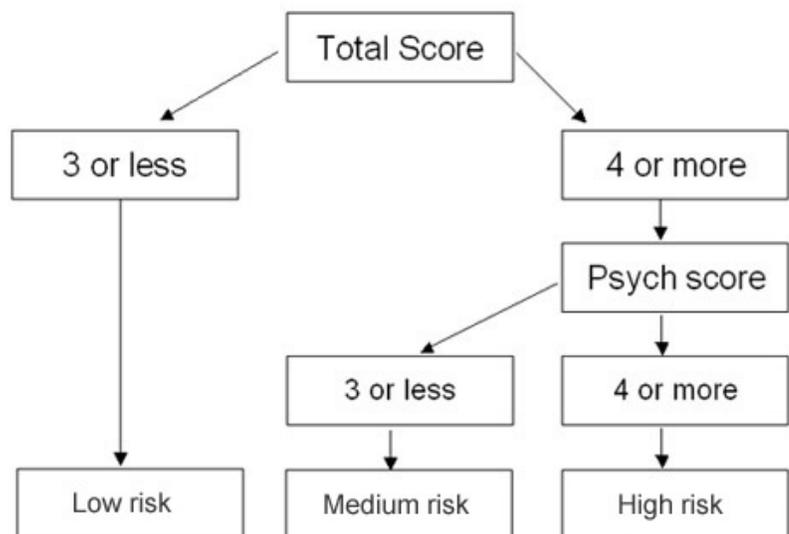
Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has <b>spread down my leg(s)</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the <b>shoulder</b> or <b>neck</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only <b>walked short distances</b> because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have <b>dressed more slowly</b> than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 <b>Worrying thoughts</b> have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that <b>my back pain is terrible</b> and <b>it's never going to get any better</b>	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have <b>not enjoyed</b> all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>				
0	0	0	1	1

Total score (all 9): \_\_\_\_\_ Sub Score (Q5-9): \_\_\_\_\_



**Tampa Scale-11 (TSK-11)**

Name:

Date:

*This is a list of phrases which other patients have used to express how they view their condition. Please circle the number that best describes how you feel about each statement.*

	<b>Strongly Disagree</b>	<b>Somewhat Disagree</b>	<b>Somewhat Agree</b>	<b>Strongly Agree</b>
1. I'm afraid I might injure myself if I exercise.	1	2	3	4
2. If I were to try to overcome it, my pain would increase.	1	2	3	4
3. My body is telling me I have something dangerously wrong.	1	2	3	4
4. People aren't taking my medical condition serious enough.	1	2	3	4
5. My accident/problem has put my body at risk for the rest of my life.	1	2	3	4
6. Pain always means I have injured my body.	1	2	3	4
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	1	2	3	4
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
9. Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
10. I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
11. No one should have to exercise when he/she is in pain.	1	2	3	4

# Yellow Flags Questionnaire (YFQ)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please circle the appropriate response for each of the following statements or questions:

1. Please indicate your usual level of pain during <b>the past week</b> :	<b>No Pain</b> 0 1 2 3 4 5 6 7 8 <b>Worst Possible Pain</b> 9 10
2. Does pain, numbness, tingling or weakness <u>extend</u> into your leg (from the low back) &/or arm (from the neck)?	<b>None Of The Time</b> 0 1 2 3 4 5 6 7 8 <b>All Of The Time</b> 9 10
3. How would you rate your general health?	<b>Poor</b> 0 1 2 3 4 5 6 7 8 <b>Excellent</b> 9 10
4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?	<b>Delighted</b> 0 1 2 3 4 5 6 7 8 <b>Terrible</b> 9 10
5. How anxious (tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during <b>the past week</b> :	<b>Not At All</b> 0 1 2 3 4 5 6 7 8 <b>Extremely Anxious</b> 9 10
6. How much you have been able to control (reduce/help) your pain/ complaint on your own during <b>the past week</b> :	<b>I Can Reduce It</b> 0 1 2 3 4 5 6 7 8 <b>I Can't Reduce It At All</b> 9 10
7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in <b>the past week</b> :	<b>Not Depressed At All</b> 0 1 2 3 4 5 6 7 8 <b>Extremely Depressed</b> 9 10
8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in <b>six months</b> ?	<b>Very Certain</b> 0 1 2 3 4 5 6 7 8 <b>Not Certain At All</b> 9 10
9. I can do light work for an hour.	<b>Completely Agree</b> 0 1 2 3 4 5 6 7 <b>Completely Disagree</b> 8 9 10
10. I can sleep at night.	<b>Completely Agree</b> 0 1 2 3 4 5 6 7 <b>Completely Disagree</b> 8 9 10
11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.	<b>Completely Disagree</b> 0 1 2 3 4 5 6 7 <b>Completely Agree</b> 8 9 10
12. Physical activity makes my pain worse.	<b>Completely Disagree</b> 0 1 2 3 4 5 6 7 <b>Completely Agree</b> 8 9 10
13. I should not do my normal activities including work with my present pain.	<b>Completely Disagree</b> 0 1 2 3 4 5 6 7 <b>Completely Agree</b> 8 9 10

Patient Signature: \_\_\_\_\_

# Yellow Flags Questionnaire (YFQ)

Name:

Date:

## Tracking & Scoring Sheet

Question		Score					
	Dates:						
<b>PAIN</b>							
1	Usual level of pain (0-10) this week (score is # circled)						
2	Frequency of radiating pain (0-10) (score is # circled)						
<b>PSYCHO-SOCIAL</b>							
3	Self-rated health (0-10) (score is 10 - # circled)						
4	Symptom satisfaction (0-10) (score is # circled)						
5	Anxiety (0-10) (score is # circled)						
6	Locus of control (0-10) (score is # circled)						
7	Depression (0-10) (score is # circled)						
8	Ability to work 6 mo. from now (0-10) (score is # circled)						
<b>FUNCTION</b>							
9	Light work tolerant for 1 hour (0-10) (score is # circled)						
10	Can sleep at night (0-10) (score is # circled)						
<b>FEAR-AVOIDANCE (Psycho-social)</b>							
11	Pain = stop activity (0-10) (score is # circled)						
12	Physical activity = worse pain (0-10) (score is # circled)						
13	Should not do normal duty? (0-10) (score is # circled)						
<b>TOTAL PAIN SCORE</b>							
<b>TOTAL PSYCHO-SOCIAL SCORE</b>							
<b>TOTAL FUNCTION SCORE</b>							
<b>TOTAL FEAR-AVOIDANCE SCORE</b>							
<b>CORE TOTAL SCORE</b>							

**Scoring & Risk (Core Total):**

**Low risk of chronic disability – under 55 points**

**Moderate risk of chronic disability – 55 to 65 points**

**High risk of chronic pain and disability – over 65 points**

# Bournemouth Questionnaire

## Neck (BQ-neck)

Name:

Date:

Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**. Please read each question carefully before answering:

1. Over the past few days, on average, how would you rate your neck pain?	<p><b>No Pain</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Worst Possible Pain</b></p>
2. Over the past few days, on average, how has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	<p><b>No Interference</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Unable to carry-on with normal day-to-day activities</b></p>
3. Over the past few days, on average, how has your neck pain interfered with your normal social routine including recreational, social, and family activities?	<p><b>No Interference</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Unable to participate in any social and recreational activities</b></p>
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	<p><b>Not Anxious At All</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Extremely Anxious</b></p>
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	<p><b>Not Depressed At All</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Extremely Depressed</b></p>
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your neck pain?	<p><b>Makes It No Worse</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Makes It Very Much Worse</b></p>
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your neck pain on your own?	<p><b>I Can Control My Pain Completely</b> 0 1 2 3 4 5 6 7 8 9 10 <b>I Have No Control Whatsoever</b></p>

**THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

# Bournemouth Questionnaire

## Back Pain (BQ-back)

Name:

Date:

Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**. Please read each question carefully before answering:

1. Over the past few days, on average, how would you rate your back pain?	<p><b>No Pain</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Worst Possible Pain</b></p>
2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	<p><b>No Interference</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Unable to carry-on with normal day-to-day activities</b></p>
3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities?	<p><b>No Interference</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Unable to participate in any social and recreational activities</b></p>
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	<p><b>Not Anxious At All</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Extremely Anxious</b></p>
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	<p><b>Not Depressed At All</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Extremely Depressed</b></p>
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain?	<p><b>Makes It No Worse</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>Makes It Very Much Worse</b></p>
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own?	<p><b>I Can Control My Pain Completely</b></p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p><b>I Have No Control Whatsoever</b></p>

**THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

# Neck Disability Index Questionnaire (NDI)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please just circle the one choice which closely describes your problem right now.***

## SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

## SECTION 2--Personal Care (Washing, Dressing etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

## SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

## SECTION 4 --Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

## SECTION 5--Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

## SECTION 6 -- Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

## SECTION 7--Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

## SECTION 8--Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

## SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

## SECTION 10--Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities all all.

DISABILITY INDEX SCORE:                      % \_\_\_\_\_

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-15.

© Vernon H & Hagino C, 1991 (with permission from Fairbank)

# Revised Oswestry Disability Index (ODI)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please just circle the one choice which closely describes your problem right now.***

## SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

## SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing or dressing without help.
- F. Because of the pain, I am unable to do any washing and dressing without help.

## SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights off of the floor.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- F. I can only lift very light weights at the most.

## SECTION 4 – Walking

- A. I have no pain walking.
- B. I have some pain walking, but I can still walk my required normal distances.
- C. Pain prevents me from walking long distances.
- D. Pain prevents me from walking intermediate distances.
- E. Pain prevents me from walking even short distances.
- F. Pain prevents me from walking at all.

## SECTION 5 – Sitting

- A. Sitting does not cause me any pain.
- B. I can sit as long as I need provided I have my choice of sitting surfaces.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than 10 minutes
- F. Pain prevents me from sitting at all.

## SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for more than one hour without increasing pain.
- D. I cannot stand for more than ½ hour without increasing pain.
- E. I cannot stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases my pain right away.

## SECTION 7 – Sleeping

- A. I have no pain in bed.
- B. I have pain in bed but it does not prevent me from sleeping well.
- C. Because of pain I only sleep ¾ of normal time.
- D. Because of pain I only sleep ½ of normal time.
- E. Because of pain I only sleep ¼ of normal time.
- F. Pain prevents me from sleeping at all.

## SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of pain.
- C. Pain prevents me from participating in more energetic activities, eg sports, dancing.
- D. Pain prevents me from going out very often.
- E. Pain has restricted my social life to home.
- F. I hardly have any social life because of pain.

## SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get some pain while traveling, but it does not cause me to seek alternative forms of travel.
- D. I get extra pain from travel that causes me to seek alternative forms of travel.
- E. Pain restricts me from all forms of travel.
- F. Pain restricts me from all forms of travel, except that done lying down.

## SECTION 10 – Employment / Homemaking

- A. My normal job/homemaking activities do not cause me pain.
- B. My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
- C. I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities eg, lifting, vacuuming.
- D. Pain prevents me from doing anything but light duties.
- E. Pain prevents me from doing even light duties.
- F. Pain prevents me from performing any job or homemaking chore.

DISABILITY INDEX SCORE:

% \_\_\_\_\_

Source: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. *Physiotherapy* 1980;66(8):271-3.

# Roland-Morris Low Back Pain & Disability Questionnaire (RMQ)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Instructions:** When your back hurts, you may find it difficult to do some of the things you normally do. Please mark only the sentences below that describe you **TODAY**.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (or stockings) because of the pain in my back.
- I can only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

\_\_\_\_\_ **Score** (# checked)

THE

# QuickDASH

OUTCOME MEASURE

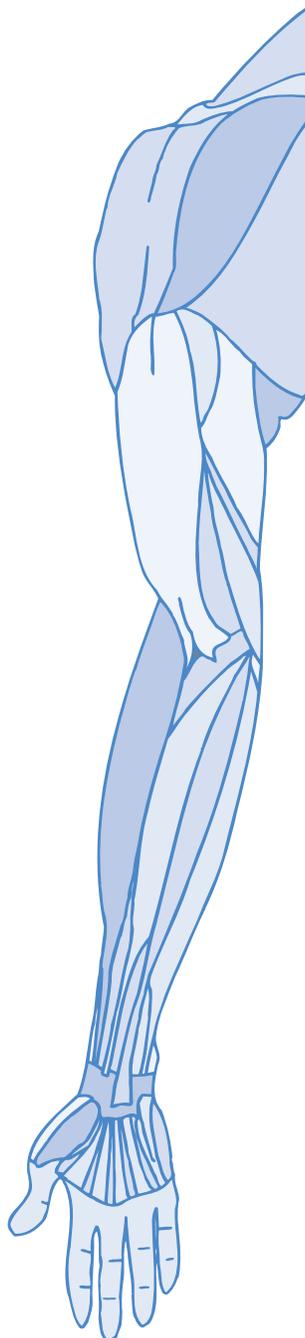
## INSTRUCTIONS

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
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. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. 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
7. During the past week, <i>to what extent</i> 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
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?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (*circle number*)

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. 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
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? ( <i>circle number</i> )	1	2	3	4	5

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

A 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.

# Shoulder Pain & Disability Index (SPADI)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please circle the number that best describes your experience during **the last week** attributable to your shoulder problem:

<b>Pain Scale:</b> How severe is your pain...	<b>0 = No Pain</b>										<b>10 = Worst Possible Pain</b>											
At its worst?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side ?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

<b>Disability Scale:</b> How much difficulty do you have...	<b>0 = No Difficulty</b>										<b>10 = So difficult it requires help</b>											
Washing your hair?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Washing your back?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Putting on an undershirt or jumper?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Putting on a shirt that buttons down the front?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Carrying an object of 10 lbs (4.5kg)?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

**Total pain score:** \_\_\_\_\_ / 50 x 100 = \_\_\_\_\_%

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 40)

**Total disability score:** \_\_\_\_\_ / 80 x 100 = \_\_\_\_\_%

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 70)

**Total SPADI score:** \_\_\_\_\_ / 130 x 100 = \_\_\_\_\_%

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 120)

The means of the two subscales are averaged to produce a total score ranging from 0 (best) to 100 (worst).

# Upper Extremity Functional Index (UEFI)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

We are interested in knowing whether you are having any difficulty at all with activities listed below **because of your upper limb problem** for which you are seeking attention. Please provide an answer for **each** activity. Today, **do you or would you have any difficulty at all with** (circle one number on each line):

ACTIVITY	Extreme Difficulty	Quite a bit of Difficulty	Moderate Difficulty	A little bit of Difficulty	No Difficulty
1. Any of your usual work, housework, or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Lifting a bag of groceries to waist level	0	1	2	3	4
4. Placing an object onto, or removing it from an overhead shelf	0	1	2	3	4
5. Washing your hair or scalp	0	1	2	3	4
6. Pushing up on your hands (from a chair or bathtub)	0	1	2	3	4
7. Preparing food (peeling, cutting, etc)	0	1	2	3	4
8. Driving	0	1	2	3	4
9. Vacuuming, sweeping or raking	0	1	2	3	4
10. Dressing	0	1	2	3	4
11. Doing up buttons	0	1	2	3	4
12. Using tools or appliances	0	1	2	3	4
13. Opening doors	0	1	2	3	4
14. Cleaning	0	1	2	3	4
15. Tying or lacing shoes	0	1	2	3	4
16. Sleeping	0	1	2	3	4
17. Laundering clothes (washing, ironing, folding, etc)	0	1	2	3	4
18. Opening a jar	0	1	2	3	4
19. Throwing a ball	0	1	2	3	4
20. Carrying a small suitcase with your affected limb	0	1	2	3	4
<b>Column Totals:</b>	_____	_____	_____	_____	_____
	Score: _____ / 80 = _____ %				

Source: Stratford P, Binkley J, Stratford D. Development and initial validation of the upper extremity functional index. Physiotherapy Canada 2001:259-266.

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# Foot & Ankle Ability Measure (FAAM)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer **every question** by circling **one response** that most closely describes your condition within the past week. If the activity in question is limited by something other than your foot or ankle, check N/A (Not Applicable)

Activity:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Standing	4	3	2	1	0	<input type="checkbox"/>
Walking on even ground	4	3	2	1	0	<input type="checkbox"/>
Walking on even ground without shoes	4	3	2	1	0	<input type="checkbox"/>
Walking up hills	4	3	2	1	0	<input type="checkbox"/>
Walking down hills	4	3	2	1	0	<input type="checkbox"/>
Going up stairs	4	3	2	1	0	<input type="checkbox"/>
Going down stairs	4	3	2	1	0	<input type="checkbox"/>
Walking on uneven ground	4	3	2	1	0	<input type="checkbox"/>
Stepping up and down curbs	4	3	2	1	0	<input type="checkbox"/>
Squatting	4	3	2	1	0	<input type="checkbox"/>
Coming up on your toes	4	3	2	1	0	<input type="checkbox"/>
Walking initially	4	3	2	1	0	<input type="checkbox"/>
Walking 5 minutes or less	4	3	2	1	0	<input type="checkbox"/>
Walking approximately 10 minutes	4	3	2	1	0	<input type="checkbox"/>
Walking 15 minutes or greater	4	3	2	1	0	<input type="checkbox"/>
<b>Because of your foot and ankle, how much difficulty do you have with:</b>						
Home responsibilities	4	3	2	1	0	<input type="checkbox"/>
Activities of Daily living	4	3	2	1	0	<input type="checkbox"/>
Personal care	4	3	2	1	0	<input type="checkbox"/>
Light to moderate work (standing, walking)	4	3	2	1	0	<input type="checkbox"/>
Heavy work (pushing/pulling, climbing, carrying)	4	3	2	1	0	<input type="checkbox"/>
Recreational activities	4	3	2	1	0	<input type="checkbox"/>
<b>Column Totals:</b>						
						<b>SCORE _____ / 84</b>

## Foot & Ankle Ability Measure (FAAM) Sports Subscale

Because of your foot and ankle, how much difficulty do you have with:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Running	4	3	2	1	0	<input type="checkbox"/>
Jumping	4	3	2	1	0	<input type="checkbox"/>
Starting and stopping quickly	4	3	2	1	0	<input type="checkbox"/>
Cutting/lateral movements	4	3	2	1	0	<input type="checkbox"/>
Ability to perform activity with your normal technique	4	3	2	1	0	<input type="checkbox"/>
Ability to participate in your desired sport as long as you like	4	3	2	1	0	<input type="checkbox"/>
<b>Column Totals:</b>						
						<b>SCORE _____ / 24</b>

Source: Martin R, Irrang J, Conti S, vanSwearingen J. Evidence of validity for the foot and ankle Ability Measure. Foot Ankle Intern 2005; 26(11):968-983.

# Lower Extremity Functional Scale (LEFS)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are seeking attention. Please provide an answer for **each** activity. Today, **do you or would you have any difficulty at all with** (circle one number on each line):

ACTIVITY	Extreme Difficulty	Quite a bit of Difficulty	Moderate Difficulty	A little bit of Difficulty	No Difficulty
1. Any of your usual work, housework, or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries, from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4
<b>Column Totals:</b>	_____	_____	_____	_____	_____
	Score: _____ / 80 = _____ %				

Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. Phys Ther 1999;79(4):371-83.

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