



TOEPPERWEIN
PHYSICAL THERAPY™
& Spine Rehab

Elbow Functional Assessment	<i>(Please mark only 1 box for each area)</i>		
	Affected Shoulder:	<input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Both
Because of my elbow pain I have difficulty putting on a shirt or coat.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I have difficulty combing or styling my hair.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I avoid overhead activities.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I avoid pushing or pulling activities because of my elbow.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I use a sling for my elbow to decrease my pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I have to hold my arm next to my side due to pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I am unable to reach behind my back to strap my bra or put on my belt.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I avoid reaching in my back pocket.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I am unable to work.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I avoid or modify recreational activities.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I avoid household chores.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I cannot throw a ball without increasing my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Resting on my elbow for more than 5 minutes hurts.	<input type="checkbox"/> True	<input type="checkbox"/> False	
When I sit, I must support my elbow with a pillow or arm rest.	<input type="checkbox"/> True	<input type="checkbox"/> False	
When I walk, swinging my arm increases my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
My elbow pain awakens me at least once a night.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of my elbow pain I am unable to drive.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I am unable to lift objects above shoulder height.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Putting on a seat belt increases my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I limit the amount of yard work I do because of my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I cannot lift a gallon of water/milk without increasing my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Because of the pain in my elbow I cannot do a push-up.	<input type="checkbox"/> True	<input type="checkbox"/> False	
Working with a computer or typewriter increases my elbow pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I need to take medication for my elbow pain in order to complete daily activities.	<input type="checkbox"/> True	<input type="checkbox"/> False	
I think using a hammer or paint brush would increase my pain.	<input type="checkbox"/> True	<input type="checkbox"/> False	
_____ / 25 Functional Restrictions			

Name: _____

Date: _____



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(Please mark only 1 box for each area)

Disabilities of the Arm, Shoulder And Hand	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Open a tight or new jar?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Do heavy household chores? (e.g. wash walls, floors)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Carry a shopping bag or briefcase?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wash your back?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Use a knife to cut food?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g., golf, hammering, tennis, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Arm, shoulder, or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tingling (pins and needles) in your arm, shoulder, hand?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	_____ / 11 Completed Responses				
Work Module	<input type="checkbox"/> I do not work. (You may skip this section)				
Using your usual technique for your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Doing your usual work because of arm, shoulder, or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Doing your work as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Spending your usual amount of time doing your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Sports/performing Arts Module	<input type="checkbox"/> I do not play a sport or an instrument. (You may skip this section)				
Using your usual technique for playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Playing your musical instrument or sport because of arm, shoulder, or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Playing your musical instrument or sport as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Spending your usual amount of time practicing or playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
DASH DISABILITY/SYMPTOM SCORE = $\frac{\{(\text{Sum of n responses}) - 1\} \times 25}{N}$, where n is equal to the number of completed responses. A Dash score may not be calculated if there are greater than 3 missing items					
Total: _____	DASH Score: _____% disability				

Name: _____

Date: _____