Welcome to Oklahoma Shoulder Center, PLLC

Registration Information

Today's Date _____

Name _____
Address _____
City _____ **State** _____ **Zip Code** _____
Home Phone _____ **Work Phone** _____
Cell Phone _____

Age _____ **Date of Birth** _____
Social Security Number _____

Marital Status (Choose One Please) __ Single __ Married __ Widowed __ Separated __ Divorced
Sex (Choose One Please) __ Male ___ Female **Are you ____ Left-Handed or ____ Right-Handed?**

Race (Choose One Please) __ Caucasian __ African American __ Other _____
Ethnicity (Choose One Please) __ Filipino __ Hispanic/Latino __ Not Hispanic/Latino

Primary Language (Choose One Please) __ English __ Spanish Other _____

Email Address _____
Consent to Email (Choose One Please) __ YES __ NO

Occupation _____
Employer _____
Employer's Address _____
Employer's Phone Number _____

Spouse's Name _____
Spouse's Employer _____

In Case of an Emergency, please contact:
Name _____
Relationship _____
Phone Number _____

Who May we Thank for Referring You?
Doctor _____
Address _____
Phone Number _____

Insurance Information

Were you injured at work? (Select One Please) _____ YES _____ NO
Were you injured in a car accident? (Select One Please) _____ YES _____NO
If you answered YES to either question above, please complete the information below:
Date of Injury _____
Adjuster's Name _____
Adjuster's Phone Number _____
Case Manager's Name _____
Case Manager's Phone Number _____
Status of Claim (Select One Please) _____ OPEN _____ CLOSED

Primary Insurance Carrier _____
Primary Policy Holder's Name _____
Primary Policy Holder's Date of Birth _____
Policy Identification Number _____
Policy Group Number _____

Secondary Insurance Carrier _____
Secondary Policy Holder's Name _____
Secondary Policy Holder's Date of Birth _____
Policy Identification Number _____
Policy Group Number _____

Authorization, Assignment, and Release

The undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Elizabeth Nolan, MD** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party **Date**

Medicare Patient Authorization Assignment and Release

I request that payment of covered Medicare benefits be made on my behalf to **Elizabeth Nolan, MD** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If other health insurance is indicated, my signature authorizes releasing of the information to the insurer or agency shown. This physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services based upon the charge determination of the Medicare carrier.

Signature of Medicare Patient **Date**

Oklahoma Shoulder Center, PLLC

If you have **Medicare Part A**, please provide us with a copy of your card in case surgery is needed.

Thank you!

Oklahoma Shoulder Center, PLLC

Confidential Health History

Name _____ Today's Date _____

Age_____ Date of Birth _____ Date of Last Physical Exam _____

What is your reason for this visit today? _____

Symptoms (Check the symptoms you currently have or have had in the past year.)

General

- ○ Chills
- ○ Depression
- ○ Dizziness
- ○ Fainting
- ○ Fever
- ○ Forgetfulness
- ○ Headache
- ○ Loss of Sleep
- ○ Weight Loss
- ○ Nervousness
- ○ Numbness
- ○ Sweats

Muscle/Joint/Bone Pain, Weakness, Numbness In:

- ○ Arms
- ○ Back
- ○ Feet
- ○ Hands
- ○ Hips
- ○ Legs
- ○ Neck
- ○ Shoulders

Genito-Urinary

- ○ Blood in Urine
- ○ Frequent Urination
- ○ Lack of Bladder Control
- ○ Painful Urination

Gastrointestinal

- ○ Poor Appetite
- ○ Bloating
- ○ Bowel Changes
- ○ Constipation
- ○ Diarrhea
- ○ Excessive Hunger
- ○ Excessive Thirst
- ○ Gas
- ○ Hemorrhoids
- ○ Indigestion
- ○ Nausea
- ○ Rectal Bleeding
- ○ Stomach Pain
- ○ Vomiting
- ○ Vomiting Blood

Cardiovascular

- ○ Chest Pain
- ○ High Blood Pressure
- ○ Irregular Heartbeat
- ○ Low Blood Pressure
- ○ Poor Circulation
- ○ Rapid Heartbeat
- ○ Swelling in Ankles
- ○ Varicose Veins

Eye/Ear/Nose/Throat

- ○ Bleeding Gums
- ○ Blurred Vision
- ○ Crossed Eyes
- ○ Difficulty Swallowing
- ○ Double Vision
- ○ Earache
- ○ Hay Fever
- ○ Hoarseness
- ○ Loss of Hearing
- ○ Nosebleeds
- ○ Persistent Cough
- ○ Ringing in Ears
- ○ Sinus Problems
- ○ Vision Flashes
- ○ Vision Halos

Skin

- ○ Bruise Easily
- ○ Hives
- ○ Itching
- ○ Change in Moles
- ○ Rash
- ○ Scars
- ○ Sores that will not Heal

All Patients

Do you have your medical marijuana license?

- ○ Yes
- ○ No

Do you smoke?

- ○ Yes
- ○ No

Women Only

Are you pregnant?

- ○ Yes
- ○ No

If you answered yes to the question above, when is your due date?

_____

Conditions (Check the conditions you have or have had in the past.)

- ○
- ○ AIDS
- ○ Alcoholism
- ○ Anemia
- ○ Anorexia
- ○ Appendicitis
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorder
- ○ Breast Lump
- ○ Bronchitis
- ○ Bulimia
- ○ Cancer
- ○ Cataracts
- ○ Non-Prescription Drugs
- ○ Chemical Dependency
- ○ Chicken Pox
- ○ Diabetes
- ○ Emphysema
- ○ Epilepsy
- ○ Glaucoma
- ○ Goiter
- ○ Gonorrhea
- ○ Gout
- ○ Heart Disease
- ○ Hepatitis
- ○ Hernia
- ○ Herpes
- ○ Herbal Supplements
- ○ High Cholesterol
- ○ HIV Positive
- ○ Kidney Disease
- ○ Liver Disease
- ○ Measles
- ○ Migraine Headaches
- ○ Miscarriage
- ○ Mononucleosis
- ○ Multiple Sclerosis
- ○ Mumps
- ○ Pacemaker
- ○ Pneumonia
- ○ Polio
- ○ Prostate Problems
- ○ Psychiatric Care
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Stroke
- ○ Suicide Attempt
- ○ Thyroid Problems
- ○ Tonsilitis

Have you ever had a blood transfusion? _____ Yes _____ No
If yes, please give us the approximate date(s) _____

Health Habits (Check which substances you use and describe how much you use.)

- Caffeine _____
- Tobacco _____
- Drugs _____
- Other _____

Occupational Concerns (Check box if your work exposes you to the following things.)

- Stress
- Hazardous Substances
- Heavy Lifting
- Other _____

Medications (List medications you are currently taking.)

_____

_____

_____

Allergies to Medications or Substances

Medication	Allergy	Reaction

Pharmacy Name _____
Pharmacy Phone Number _____

Family History (Fill in the health information about your family.)

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Check Box if any of your blood relatives have had any of the following diseases.

Disease	Relationship to You
○ Arthritis, Gout	
○ Asthma, Hay Fever	
○ Cancer	
○ Chemical Dependency	
○ Heart Disease, Strokes	
○ Diabetes	
○ High Blood Pressure	
○ Kidney Disease	
○ Tuberculosis	
○ Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization	Outcome

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his or her staff responsible for any error or omissions that I may have made in completion of this form.

Signature **Date**

Oklahoma Shoulder Center, PLLC
Consent for Treatment and Financial Responsibility

As a patient of Oklahoma Shoulder Center, PLLC, I authorize the physicians to examine, diagnose, and render all treatment as they deem necessary. If care is needed for my minor, disabled child, or relative custodial to me, I authorize the same treatment for them also.

I have requested that Oklahoma Shoulder Center, PLLC bill my insurance company for covered services provided by the physicians here on my behalf. I authorize payment directly to them. I understand that it is still my responsibility to make sure that the bill is paid in a reasonable time. If, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I understand that I am financially responsible for all charges not covered by this assignment.

I further understand that it is my responsibility to obtain referrals from my primary care physician- prior to my visits- if I have a HMO plan, and I agree to pay in full for the office visit in the event that this is not obtained prior to my seeing the physician.

I further agree in the event of non-payment to bear the cost of collection and/or court costs and reasonable legal fees should this be required.

In order to process a claim for benefits, I authorize the physicians and their representatives at Oklahoma Shoulder Center to release to my insurance company any information regarding my medical history, treatment, symptoms, examination results, or diagnosis necessary for payment of the claim. If this is a Workers Compensation Claim, I authorize release of information to this carrier also- whether written or oral- for payment of this claim.

If I am not insured, I assume full responsibility for all charges for services rendered and agree to pay in full at the time of my visit. I understand that it is not the policy of Oklahoma Shoulder Center, PLLC to bill me for services. Payment is due in full when services are rendered.

Signature of Patient **Date**

Oklahoma Shoulder Center

Notice of Privacy Practices Medical

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form- whether electronically, by paper, or orally- are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we can use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes as defined below:

- **Treatment**: providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of treatment would include physical examination.
- **Payment**: includes obtaining reimbursement for services, confirming coverages, billing or collection activities, and utilization review. An example of payment would include sending a claim for your visit to your insurance company for payment.
- **Healthcare Operations**: the business aspects of running the medical practice, including, but not limited to, conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of healthcare operations would be an internal quality assessment review.

We may also create and distribute deidentified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations
- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 13, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice's provisions effective for all protected health information that we maintain. We will post- and you may request- a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPAA or to file a complaint:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
Phone: (202) 619-0257
Toll Free Phone: (877) 6969-6775

Oklahoma Shoulder Center, PLLC

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians' certifications

I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Oklahoma Shoulder Center, PLLC
725 NW 11th Street
Oklahoma City, OK 73103
Phone: (405) 278-8006
Fax: (405) 290-7388

Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI)

Patient Name _____

Date of Birth _____ **Social Security Number** _____

Medical Record Number _____

I hereby authorize _____

Name of Person/Organization Disclosing PHI

To release the following information to _____

Name and Address of Person/Organization Receiving PHI

Information to be shared:

- ○ Psychotherapy Notes (If checking this box, no other boxes may be checked)
- ○ Entire Medical Record
- ○ Billing Information for _____
- ○ Substance Abuse Records
- ○ Mental Health Records
- ○ Medical Information compiled between _____ and _____
- ○ Other _____

The information may be disclosed for the following purpose(s) only:

- ○ Insurance
- ○ Continued Treatment
- ○ Legal
- ○ At my or my representative's request
- ○ Other

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person or organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, HIV, or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand that I may change this authorization at any time by writing to the person or organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

  Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following: _____.

Signature of Patient or Legal Representative **Date**

Description of Legal Representative's Authority

Expiration Date (If longer than one year from date of signature or no event is indicated)

Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute, including but not limited to whether any medical services rendered under this contract were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Oklahoma law, and not by a lawsuit or resort to court process except as Oklahoma law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law before a jury and instead are accepting the use of arbitration.

Article 2: **All Claims must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expect child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partner, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including council fees or witness fee, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any exiting court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of Oklahoma law applicable to health care provider shall apply to disputes within this arbitration agreement. Any party may bring before the arbitrations a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred

if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Oklahoma statute of limitation, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Oklahoma laws relating to arbitration.

Article 5: **Intent**: It is the intent of this agreement to apply to all medical services rendered any time for any condition. This agreement is effective as of the date of the first medical services provided.

Article 6: **Severability**: If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement upon requesting one. By my signature below, I acknowledge that I have received or have waived receipt of a copy.

Notice: By signing this contract you are agreeing to have any issue in dispute decided by neutral arbitration, and you are giving up your right to a jury or court trial. See Article 1 of this contract.

By: _____ Date: _____
Patient's or Representative's Signature

_____
Patient's Printed Name

By: Oklahoma Shoulder Center, PLLC Dated: 01/01/2016
(Typed company name and date is to act as signature of practice for this document only.)

A signed copy of this document is to be given to the patient upon request. Original is to be filed in the patient's medical records.

Pain Management Policy

The appropriate management of the chronic pain should rely primarily on non-opioid therapies and should incorporate a multimodal treatment plan to obtain the best outcome for the patient. As per Oklahoma state laws established in 2018, treatment of acute pain- such as normal anticipated pain after surgery- is limited to a 7 day prescription for narcotic medications with only one refill allowed, and no longer allowed after 2 weeks.

Given these constraints and lack of other infrastructure, it is the policy of this practice that no narcotic medication can be prescribed after the 2 week post-operative period.

Your signature affirms that you have read and agree to abide by this policy. Any pain requiring narcotic medication past the 2 week acute pain window, as defined by Oklahoma law, is considered chronic pain management. This office does not provide chronic pain management.

We realize that opioids have risks that require vigilance to identify patients with Opioid Use Disorder, addiction, and diversion.

Patient's Signature _____

Patient's Printed Name _____

SANE (Single Assessment Numeric Evaluation)

"How would you rate your affected joint/region of interest today as a percentage of normal (0% to 100% scale with 100% being normal)?"

"How would you rate your opposite side today as a percentage of normal (0% to 100% scale with 100% being normal)?"

Global Health

Please respond to each item by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		Completely	Mostly	Moderately	A little	Not at all
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

		None	Mild	Moderate	Severe	Very severe
Global08	How would you rate your fatigue on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Global07	How would you rate your pain on average?.....	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst imaginable pain

orthotoolkit

American Shoulder and Elbow Surgeons Score (ASES)

Patient Name: _____

Date: _____

Dominant Hand: R L Both (Circle One)

Affected Shoulder: R L (Circle One)

Pain Questionnaire

1. Usual Work

_____

2. Usual Sport/Leisure Activity

_____

3. Do you have shoulder pain at night (circle one)?

Yes No

4. Do you take pain killers such as paracetamol (acetaminophen), diclofenac, or ibuprofen (circle one)?

Yes No

5. Do you take strong pain killers such as codeine, tramadol, or morphine (circle one)?

Yes No

6. How many pills do you take on an average day?

_____

7. Intensity of pain (circle one)?

0	1	2	3	4	5	6	7	8	9	10
No pain at all								Pain as bad as it can be		

Activities of Daily Living Questionnaire

8. Is it difficult for you to put on a coat?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

9. Is it difficult for you to sleep on the affected side?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

10. Is it difficult for you to wash your back/do up bra?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

11. Is it difficult for you to manage toileting?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

12. Is it difficult for you to comb your hair?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

13. Is it difficult for you to reach a high shelf?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

14. Is it difficult for you lift 10lbs. (4.5kg) above your shoulder?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

15. Is it difficult for you to throw a ball overhand?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

16. Is it difficult for you to do your usual work?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

17. Is it difficult for you to do your usual sport/leisure activity?

☐ Unable to do	+0
☐ Very difficult to do	+1
☐ Somewhat difficult	+2
☐ Not difficult	+3

Scoring Guide:

Pain Questionnaire:
Question 7 Value: _____ Points

Pain Score: $5 \times (10 - \textit{Question 7 Value})$

Pain Score: _____ Points

Activities of Daily Living (ADL) Questionnaire:
ADL Raw Score: Summation of points

ADL Raw Score: _____ Points

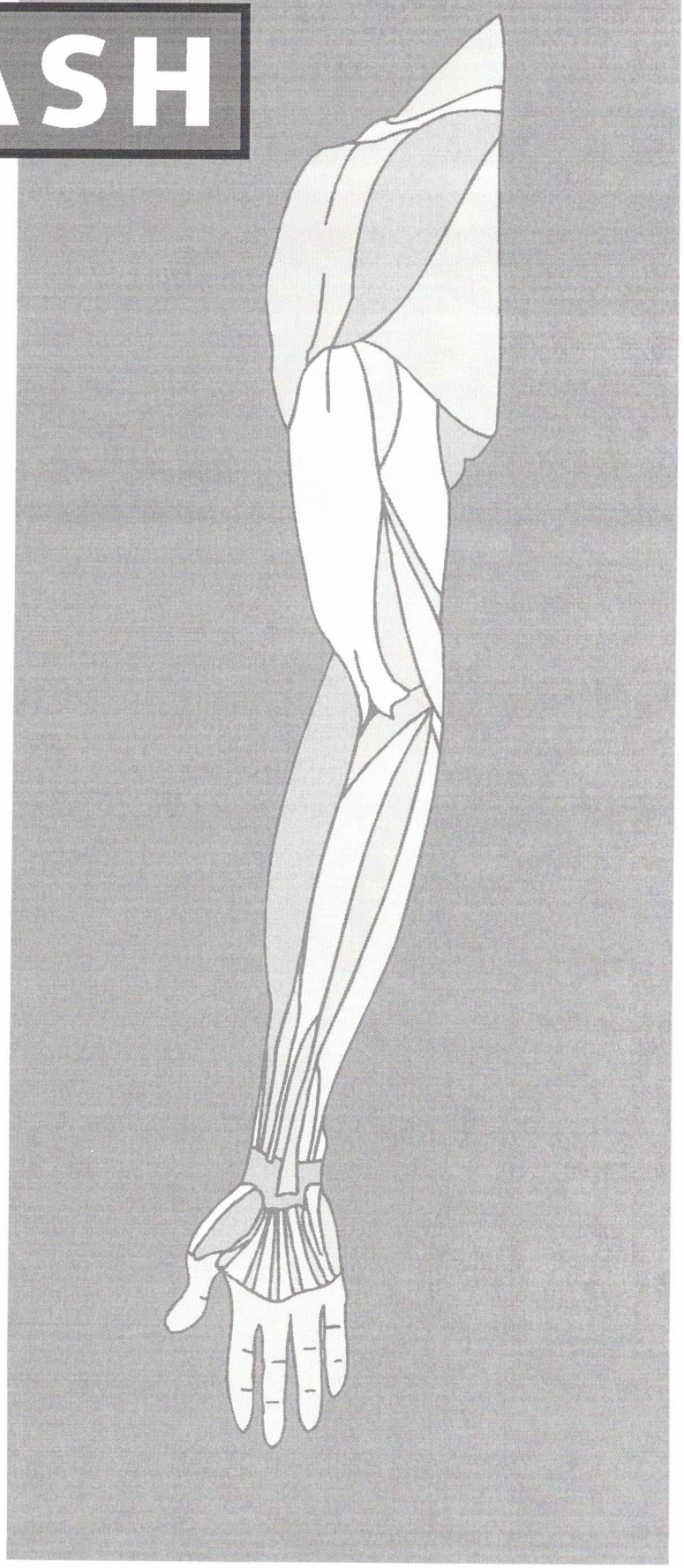
ADL Score: $\dfrac{5 \times (\textit{raw score})}{3}$

ADL Score: _____ Points

Final ASES Score:
Final Score: Pain Score + ADL Score

Final score: _____ Points

THE DASH



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* on 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.

Disabilities of the Arm, Shoulder and Hand

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. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. 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
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. 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? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. 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? *(circle number)*	1	2	3	4	5

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

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness 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
29. 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

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

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

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making 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 <u>not</u> be calculated if there are any missing items.

Institute for Work & Health | Research Excellence Advancing Employee Health