

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

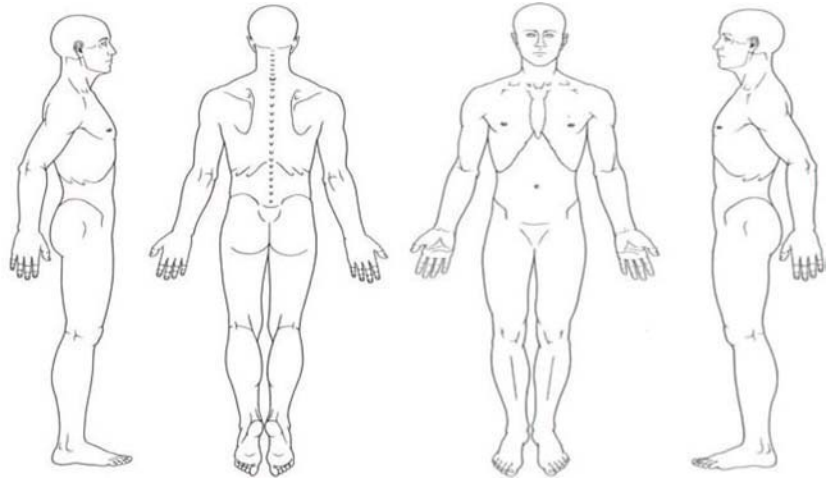
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Disability of the Arm, Shoulder, and Hand (DASH)

“The DASH is a 30-item self-report questionnaire designed to measure physical function items, six symptom items, and three social/role function items.”¹ “The DASH is designed to measure physical disability and symptoms in a heterogeneous population that includes both males and females; people who place low, moderate, or high demands on their upper limbs during their daily lives (work, leisure, self-care); and people with a variety of upper-limb disorders.”¹

Scoring

Patients are asked to answer all sections and respond based on their ability to perform activities over the past week; only one answer per question.

At least 27 of the 30 items **must** be completed for scoring.

The assigned values are summed and divided by the number of questions answered. This value is transformed to a score out of 100 by subtracting 1 and multiplying by 25.

$$\text{DASH} = \left\{ \frac{(\text{sum of } n \text{ responses})}{n} - 1 \right\} \times 25 \quad n = \text{total number of questions answered}$$

Minimum detectable change (MDC): 12.7 points; current literature holds 12.7 points to be the minimal change in score to be statistically significant at the 95% confidence interval.²

Minimum clinically important difference (MCID): 15 points; this represents the change in score needed to be considered clinically significant.²

¹Solway S, Beaton DE, McConnell S, Bombardier C. The DASH Outcome Measure User’s Manual, Second Ed. Toronto, Ontario: Institute for Work and Health, 2002.

²Beaton DE, Davis AM, Hudak P, McConnell S. The DASH (Disabilities of the Arm, Shoulder, and Hand) outcome measure: What do we know about it now? British Journal of Hand Therapy 2001; 6(4):109-118.

Please visit the DASH website at www.dash.iwh.on.ca for further references.

ACN Group requests an outcome measure be completed on the initial submission (**baseline**), requests for additional services (**response to treatment**), and at patient discharge (**effectiveness of intervention**).

PT/OT Patient Summary Form

ACN Group, Inc Form PSF-002

Instructions: Complete this form and submit via web, email, or fax to ACN Group within 3 days of the initial date of service. www.acnprovider.com

Female Male

Patient's Name (Last, First, MI) _____

Referral Info (if required by health plan as stated on your Plan Summary): Referred Yes No

Referring Doctor: _____ Date Referral Issued: _____

Type of Service: PT only OT only Both PT and OT

Nature of Condition: 1 Initial onset (within last 3 months) 2 Recurrent (multiple episodes of <3 months) 3 Chronic (continuous duration >3 months)

The date you want this Patient Summary to begin: _____

Cause of Current Episode: 1 Traumatic 2 Unspecified 3 Repetitive 4 Post-surgical 5 Virus related 6 Motor Vehicle

Anticipated Treatment Duration (weeks): 4 6 8 12 16 20

Functional Outcome Measure Score: Neck Index: _____ DASH: _____ Back Index: _____ LEFS: _____

Date of Surgery: _____ Type of Surgery: 1 ACL Recon 2 Rotator Cuff/Labral Repair 3 Tendon Repair 4 Spinal Fusion 5 Joint Replacement

Insert Score Here

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

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)

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

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
1	1	2	3	4	5

Rate the severity of the following symptoms in the last week. (circle number)

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

During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
1	1	2	3	4	5

During the past week, how much less capable, less confident or less useful because of my arm, shoulder or hand problem. (circle number)

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
1	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = 05.83 ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

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

$$\text{DASH} = \left\{ \frac{\text{sum of } n \text{ responses}}{n} - 1 \right\} \times 25$$

$$\text{DASH} = \left\{ \left(\frac{73}{30} - 1 \right) \right\} \times 25 = 35.83\%$$

THE

DASH

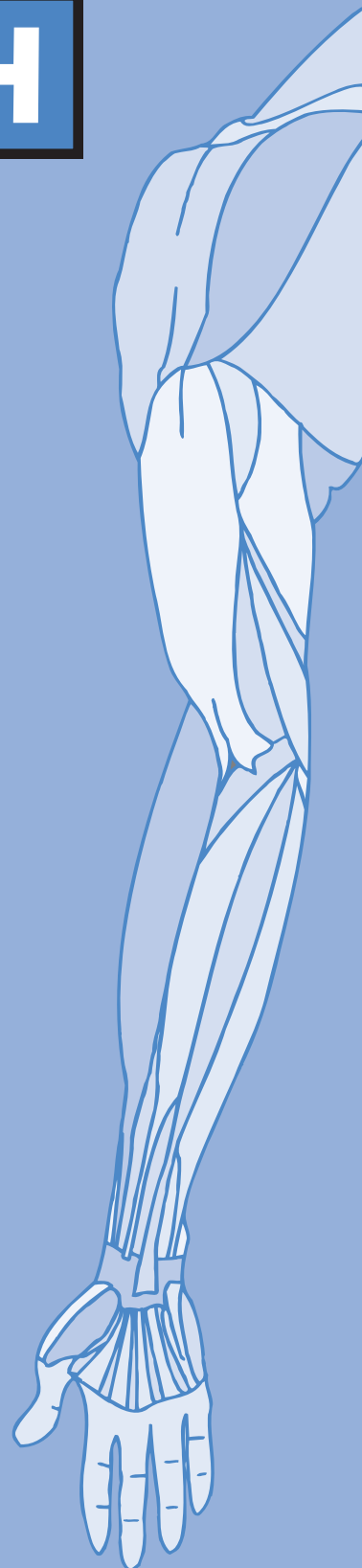
INSTRUCTIONS

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, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? <i>(circle number)</i>	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? <i>(circle number)</i>	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? <i>(circle number)</i>	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. <i>(circle number)</i>	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\frac{[(\text{sum of } n \text{ responses}) - 1] \times 25}{n}$, 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.

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 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.