



# Upper Extremities Index



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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.

	1 No Difficulty	2 Mild Difficulty	3 Moderate Difficulty	4 Severe Difficulty	5 Unable
1. Open a tight or new jar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Do heavy household chores (e.g., wash walls, floors)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Carry a shopping bag or briefcase	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Wash your back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Use a knife to eat food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All	Slightly	Moderately	Quite a Bit	Extremely
7. 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	None	Mild	Moderate	Severe	Extreme

Please rate the severity of the following symptoms in the last week:

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much Difficulty That I Can't Sleep
9. Arm, shoulder or hand pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Tingling (pins and needles) in your arm, shoulder or hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Once you complete the questions, please circle the category that is most important to you or is your biggest issue at this time.

TO BE COMPLETED BY TherapySouth:

$$\left[ \frac{\text{Sum of all responses selected}}{\text{\# of completed responses}} - 1 \right] \times 25 = \boxed{\phantom{0000}} \text{ Upper Extremities Index Score}$$