

Scapula Fracture Study

Patient Outcomes Form

Patient Study ID = _____

Today's Date (MM/DD/YY) = _____

Follow-up Interval: Initial 2weeks 6weeks
 12weeks 24weeks 52weeks

Part I -- SMFA

Directions: We are interested in finding out how you are managing with your injury or arthritis this week. We would like to know about any problems you may be having with your daily activities because of your injury or arthritis. Please answer each question by shading in the circle corresponding to the choice that best describes you.

Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●

These questions are about how much difficulty you may be having <u>this week</u> with your daily activities because of your injury or arthritis.						
		Not at all difficult	A little difficult	Moderately difficult	Very difficult	Unable to do
01.	How difficult is it for you to get in or out of a low chair?	○	○	○	○	○
02.	How difficult is it for you to open medicine bottles or jars?	○	○	○	○	○
03.	How difficult is it for you to shop for groceries or other things?	○	○	○	○	○
04.	How difficult is it for you to climb stairs?	○	○	○	○	○
05.	How difficult is it for you to make a tight fist?	○	○	○	○	○
06.	How difficult is it for you to get in or out of the bathtub or shower?	○	○	○	○	○
07.	How difficult is it for you to get comfortable to sleep?	○	○	○	○	○
08.	How difficult is it for you to bend or kneel down?	○	○	○	○	○
09.	How difficult is it for you to use buttons, snaps, hooks, or zippers?	○	○	○	○	○
10.	How difficult is it for you to cut your own fingernails?	○	○	○	○	○
11.	How difficult is it for you to dress yourself?	○	○	○	○	○
12.	How difficult is it for you to walk?	○	○	○	○	○
13.	How difficult is it for you to get moving after you have been sitting or lying down?	○	○	○	○	○
14.	How difficult is it for you to get out by yourself?	○	○	○	○	○
15.	How difficult is it for you to drive?	○	○	○	○	○
16.	How difficult is it for you to clean yourself after going to the bathroom?	○	○	○	○	○
17.	How difficult is it for you turn knobs or levers, for example, open doors, roll down car windows?	○	○	○	○	○
18.	How difficult is it for you to write or type?	○	○	○	○	○
19.	How difficult is it for you to pivot?	○	○	○	○	○

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20.	How difficult is it for you to do your usual physical recreational activities, such as bicycling, jogging, or walking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	How difficult is it for you to do your usual leisure activities, such as hobbies, crafts, gardening, card playing, going out with friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	How much difficulty are you having with sexual activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	How difficult is it for you to do <u>light</u> housework <u>or</u> yardwork, such as dusting, washing dishes, or watering plants?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	How difficult is it for you to do <u>heavy</u> housework <u>or</u> yardwork, such as washing floors, vacuuming, or mowing lawns?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	How difficult is it for you to do your usual work, such as a paid job, housework, volunteer activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next questions ask how often you are experiencing problems this week because of your injury or arthritis

		<u>None of the time</u>	<u>A little of the time</u>	<u>Some of the time</u>	<u>Most of the time</u>	<u>All of the time</u>
26.	How often do you walk with a limp?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	How often do you avoid using your painful limb(s) or back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	How often does your leg lock or give-way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29.	How often do you have problems with concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	How often does doing too much in one day affect what you do the next day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	How often do you act irritable toward those around you, for example, snap at people, give sharp answers, or criticize easily?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	How often are you tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33.	How often do you feel disabled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34.	How often do you feel angry or frustrated that you have this injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next questions are about how much you are bothered by problems you are having this week due to your injury or arthritis

		<u>Not bothered at all</u>	<u>A little bothered</u>	<u>Moderately bothered</u>	<u>Very bothered</u>	<u>Extremely bothered</u>
35.	Problems using your hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36.	Problems using your back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37.	Problems doing work around your	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	home?					
38.	Problems with bathing, dressing, toileting or other personal care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39.	Problems with sleep and rest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40.	Problems with leisure or recreational activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41.	Problems with your friends, family or other important people in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42.	Problems with thinking, concentrating or remembering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43.	Problems adjusting or coping with your injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44.	Problems doing your usual work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45.	Problems with feeling dependent on others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46.	Problems with stiffness and pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part II – DASH Questionnaire

Directions: 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.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight 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

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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

	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, neighbors, or groups?	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?	1	2	3	4	5

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Directions: 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	UNABLE TO SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?	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.	1	2	3	4	5

Part III – ASES

Directions: Please circle the answer that best represents your current state of health in regards to your injured shoulder.

	LEFT SHOULDER					RIGHT SHOULDER						
1. Are you having pain in your shoulder?	Yes	No				Yes	No					
2. How much pain do you have in your shoulder?	None	Mild				None	Mild					
	Moderate	Severe				Moderate	Severe					
3. Do you have pain in your shoulder at night?	Yes	No				Yes	No					
4. How bad is your pain today on a scale from 0 to 10? (0 = no pain at all, 10 = pain as bad as it can be)	0	1	2	3	4	5	0	1	2	3	4	5
	6	7	8	9	10		6	7	8	9	10	
5. Does your shoulder feel unstable (as if it is going to dislocate)?	Yes	No				Yes	No					
6. How unstable is your shoulder today on a scale from 0 to 10? (0 = very stable, 10 = very unstable)	0	1	2	3	4	5	0	1	2	3	4	5
	6	7	8	9	10		6	7	8	9	10	

7. Do you take pain medications (aspirin, Tylenol, Advil, etc.)? Yes No

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8. Do you take narcotic pain medication (Codeine or stronger)? Yes No

9. How many pills do you take each day (average)? _____ pills

Circle the number in the box that indicates your ability to do the following activities:

0 = Unable to do; 1 = Very difficulty to do; 2 = Somewhat difficult; 3 = Not difficult

	LEFT ARM				RIGHT ARM			
10. Put on a coat	0	1	2	3	0	1	2	3
11. Sleep on your painful or affected side	0	1	2	3	0	1	2	3
12. Wash back / do up bra in back	0	1	2	3	0	1	2	3
13. Manage toileting	0	1	2	3	0	1	2	3
14. Comb hair	0	1	2	3	0	1	2	3
15. Reach a high shelf	0	1	2	3	0	1	2	3
16. Lift 10 lbs. above shoulder	0	1	2	3	0	1	2	3
17. Throw a ball overhand	0	1	2	3	0	1	2	3
18. Do usual work List: _____	0	1	2	3	0	1	2	3
19. Do usual sport List: _____	0	1	2	3	0	1	2	3
20. Are you able to do your work as fully as usual?	Yes No				Yes No			
21. Are you able to participate in recreational activities as fully as usual?	Yes No				Yes No			
22. Is your sleep affected by your shoulder?	Yes No				Yes No			
23. How high can you reach your hand?	Up to waist Up to sternum Up to neck Up to top of head Above head				Up to waist Up to sternum Up to neck Up to top of head Above head			