HAND QUESTIONNAIRE

Patient Name: _____

Date: _____

DOB: _____

Referred by: _____

Dominant Hand: **[ ]** RIGHT **[ ]** LEFT

Occupation: _____

Hobbies/Sports/Musical Instruments: _____

_____

Side involved: **[ ]** RIGHT **[ ]** LEFT **[ ]** BOTH

Location: **[ ]** ELBOW **[ ]** WRIST **[ ]** THUMB **[ ]** INDEX **[ ]** MIDDLE
[ ] RING **[ ]** SMALL

Onset of symptoms: _____

If Specific event, date: _____

Description of injury: _____

_____

Initial symptoms: _____

_____

Symptoms now: _____

_____

Time of symptoms: **[ ]** CONSTANTLY **[ ]** INTERMITTENTLY **[ ]** MORNING
[ ] EVENING **[ ]** NIGHT
[ ] W/ACTIVITY/TYPE OF ACTIVITY: _____
____ _____

Work status since injury: **Currently working:** **[ ]** YES **[ ]** NO
If YES: **[ ]** REGULAR DUTY **[ ]** LIGHT DUTY

Treatment to date:	**How long/When?**	**Treatment by:**	**Effect:**
[ ] None			
[ ] Splinting			
[ ] Cast			
[ ] NSAIDS			
[ ] Therapy			
[ ] Injections			
[ ] Surgery			

Previous tests: **[ ]** X-rays **[ ]** Nerve studies/EMGs **[ ]** MRI **[ ]** CT