



Left Elbow Questionnaire

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Primary Care Physician: _____ Referred by: _____

Date of Injury or Onset: _____ Occupation: _____

Please indicate answers by completely filling in the applicable circles.

Dominant Hand: ☐ LEFT ☐ RIGHT

Is there pain? ☐ YES ☐ NO

If YES, describe your pain: (mark all that apply)

<input type="checkbox"/> dull	<input type="checkbox"/> sharp	<input type="checkbox"/> stabbing	<input type="checkbox"/> burning	<input type="checkbox"/> aching
<input type="checkbox"/> throbbing	<input type="checkbox"/> shooting	<input type="checkbox"/> squeezing	<input type="checkbox"/> pressure	<input type="checkbox"/> crampy
<input type="checkbox"/> worsening	<input type="checkbox"/> better since onset			

Pain is worse when: ☐ grasping ☐ lifting ☐ bending ☐ stretching
(mark all that apply)

Pain is located: ☐ top ☐ bottom ☐ inside ☐ outside
(mark all that apply)

Please rate your pain **0 = no pain** **10 = extreme pain**

Pain Today: 0 0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 0 10

Pain at Best: 0 0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 0 10

Pain at Worst: 0 0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 0 10

Was there an injury? ☐ YES ☐ NO If YES, was it work related? ☐ YES ☐ NO

What happened to your elbow?

There is: (mark all that apply)

<input type="checkbox"/> locking or catching	<input type="checkbox"/> giving way	<input type="checkbox"/> popping	<input type="checkbox"/> stiffness or loss of motion
<input type="checkbox"/> increased warmth	<input type="checkbox"/> bruising	<input type="checkbox"/> redness	<input type="checkbox"/> numbness or tingling
<input type="checkbox"/> swelling	<input type="checkbox"/> none of the above		

On this elbow, you have had prior: ☐ x-rays ☐ MRIs ☐ CT scans ☐ EMGs ☐ nerve studies ☐ surgery
(mark all that apply) ☐ **none of the above**

Treatments Tried in the Past: (mark all that apply)

<input type="checkbox"/> anti-inflammatories	<input type="checkbox"/> brace	<input type="checkbox"/> splint
<input type="checkbox"/> pain medication	<input type="checkbox"/> fluid drained	<input type="checkbox"/> injection
<input type="checkbox"/> physical therapy	<input checked="" type="checkbox"/> none of the above	

Please mark all activities in which you participate:

<input type="radio"/> football	<input type="radio"/> baseball	<input type="radio"/> softball	<input type="radio"/> basketball	<input type="radio"/> soccer
<input type="radio"/> hockey	<input type="radio"/> lacrosse	<input type="radio"/> volleyball	<input type="radio"/> cross country	<input type="radio"/> running
<input type="radio"/> swimming	<input type="radio"/> skiing	<input type="radio"/> tennis	<input type="radio"/> racquetball	<input type="radio"/> handball
<input type="radio"/> bowling	<input type="radio"/> golf	<input type="radio"/> horseback riding	<input type="radio"/> skateboarding	<input type="radio"/> surfing
<input type="radio"/> climbing	<input type="radio"/> rowing	<input type="radio"/> fishing	<input type="radio"/> yard work	<input type="radio"/> heavy housework
<input type="radio"/> video games	<input type="radio"/> guitar/bass	<input type="radio"/> piano	<input type="radio"/> drums	<input type="radio"/> musical instruments