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Direction of Feed

Hand / Upper Extremity

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

AGE

AFFECTED SIDE

	left	right	both
hand	○	○	○
wrist	○	○	○
elbow	○	○	○

	left	right	both
upper arm	○	○	○
forearm	○	○	○
finger(s)	○	○	○

DOMINANT HAND

- ○ right
- ○ left
- ○ ambidextrous (both)

REFERRED BY

- ○ self
- ○ I was referred by: _____

ONSET OF SYMPTOMS

Which best describes how your symptoms began?

- ○ gradual onset
- ○ sudden onset
- ○ due to an injury

How long ago did the symptoms begin?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ >10 ○

- ○ **days ago**
- ○ **weeks ago**
- ○ **months ago**
- ○ **years ago**

SETTING

- ○ at work
- ○ at school
- ○ at home
- ○ during athletic activities
- ○ non-vehicle accident
- ○ motor vehicle accident
- ○ during recreational activities
- **other:** _____

MECHANISM

- ○ athletic overuse
- ○ bending
- ○ burn
- ○ hand caught on clothing
- ○ finger caught on clothing
- ○ direct blow
- ○ fell on outstretched hand
- ○ fell on arm
- ○ fingernail trauma
- ○ forced bending of joint
- ○ hyperextension
- ○ laceration
- ○ crush injury
- ○ puncture wound (fingernail)
- ○ puncture wound (finger/s)
- ○ pulling
- ○ lifting
- ○ repetitive motion
- ○ twisting
- ○ forced bending of wrist
- ○ prolonged keyboard use
- ○ reaching
- **other:** _____

PAIN

Are you currently experiencing pain? ○ yes ○ no

How much pain are you experiencing...

0 = no pain **10 = intolerable**

NOW: ☺ No Pain — 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 — ☹ Intolerable

AT ITS WORST: ☺ No Pain — 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 — ☹ Intolerable

TIMING

- ○ constant
- ○ intermittent
- ○ occasional
- ○ rare
- ○ daytime
- ○ nighttime
- **other:** _____

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Hand / Upper Extremity

Please answer every question

***STAFF:** Handwritten items must be entered **MANUALLY**.*

SEVERITY & QUALITY

- ◯ sharp
- ◯ dull
- ◯ burning
- ◯ aching
- ◯ stinging
- ◯ throbbing
- ◯ stabbing
- **other:** _____

PRESENT SYMPTOMS / COMPLAINTS

- ◯ catching
- ◯ numbness
- ◯ stiffness
- ◯ locking
- ◯ swelling
- ◯ weakness
- ◯ discomfort
- ◯ loss of range of motion
- ◯ tingling
- **other:** _____ _____

WHAT MAKES YOUR PAIN WORSE?

- ◯ extending
- ◯ gripping
- ◯ bending
- ◯ repetitive motion
- ◯ rotation
- ◯ lifting
- **other:** _____ _____

WHAT MAKES YOUR PAIN BETTER?

- ◯ **nothing makes the pain better**
- ◯ prescription medication
- ◯ over-the-counter medication
- ◯ injections
- ◯ physical therapy
- ◯ using a brace
- ◯ using a splint
- ◯ elevation
- ◯ massage
- ◯ stretching
- ◯ ice
- ◯ heat
- ◯ rest
- ◯ previous surgery
- ◯ chiropractor
- **other:** _____

WORK HISTORY

Was this a work related injury? ◯ yes ◯ no

Are you currently working?

- ◯ no (If no, when did you last work?): _____
- ◯ yes
- ◯ disabled
- ◯ retired
- ◯ student

Are you currently on any work restrictions?

- ◯ no
- ◯ yes (please explain): _____

Occupation: _____ **Employer:** _____

CURRENT SYMPTOMS

Please mark all symptoms you are CURRENTLY experiencing.
Mark all that apply. If no symptoms in a category, please mark "NONE."

GENERAL	trouble sleeping ◯ recent weight loss ◯	fatigue ◯ loss of appetite ◯	**NONE** ◯
CARDIOVASCULAR	chest pain ◯	palpitations ◯	**NONE** ◯
SKIN	frequent rashes ◯ skin ulcers ◯	lumps ◯ non-healing wound ◯	**NONE** ◯
EAR / NOSE / THROAT	hearing loss ◯	hoarseness ◯ trouble swallowing ◯	**NONE** ◯
ENDOCRINE	cold intolerance ◯	heat intolerance ◯	**NONE** ◯
EYES	vision loss ◯	blurred vision ◯ double vision ◯	**NONE** ◯
GASTROINTESTINAL	heartburn ◯ nausea ◯	vomiting ◯ blood in stool ◯	**NONE** ◯
GENITOURINARY	blood in urine ◯	painful urination ◯	**NONE** ◯
HEMATOLOGIC / LYMPHATIC	easy bruising ◯	easy bleeding ◯	**NONE** ◯
NEUROLOGICAL	headaches ◯	dizziness ◯ numbness ◯	**NONE** ◯
PSYCHIATRIC	feeling anxious ◯	feeling depressed ◯	**NONE** ◯
RESPIRATORY	chronic cough ◯	shortness of breath ◯	**NONE** ◯

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