

HAND / WRIST

Was this an injury or did it occur over time? _____

How long have you had this problem or what was the date of your injury? _____

Which hand has the problem? Left / Right

Where do you have the problem? Wrist / Hand / Fingers: Thumb / Index / Long / Ring / Pinky

If an injury, describe how it occurred: _____

Have you had this or a similar problem before? Yes / No

If yes, how was it treated? _____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull	Constant Burn
Come and go	Pins & needles	Electric	Explosive	Unrelenting
Throbbing	Constant	Intermittent	Chronic	Unchanged
Getting better	Getting worse	Other _____		
Worse in the morning	Worse in the evening	Worse at night		

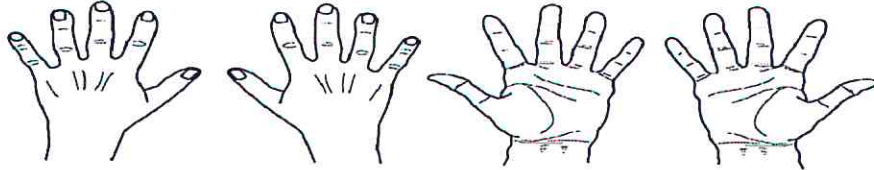
What makes your pain **worse**? _____

What makes your pain **better**? _____

Medications used for this problem: _____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other _____

Please indicate the location of your pain with an X:



Do you have numbness or tingling? Yes / No If yes, where? _____

Do you have swelling? Yes / No If yes, where? _____

Do you have popping / catching / grinding?

Do you have weakness of grip? Yes / No

Do you have neck pain? Yes / No

Have you ever had any surgery on your: Hand / Wrist / Neither

Do you have any other problems not previously described? Yes / No If yes, please describe: _____

Referring Physician: _____

Other Physician(s) you have seen for this problem: _____

Date(s) of work/school missed for this problem: _____

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information: _____

Patient Name (*print*): _____ Patient Signature: _____ Date: _____