

Hand/Wrist

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

Date of injury or How long you have had this problem: _____

Which hand has the problem? Left / Right

Where do you have the problem? wrist / hand / fingers: thumb / index / long / ring / little

If an injury, describe how it occurred: _____

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

If so, 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 burning | | Come and go | Pins & Needles |
| Explosive | Unrelenting | Throbbing | Electric |
| Constant | Intermittent | Chronic | |
| Getting better | Getting worse | Unchanged | |
| Worse in morning | Worse in evening | Worse at night | |

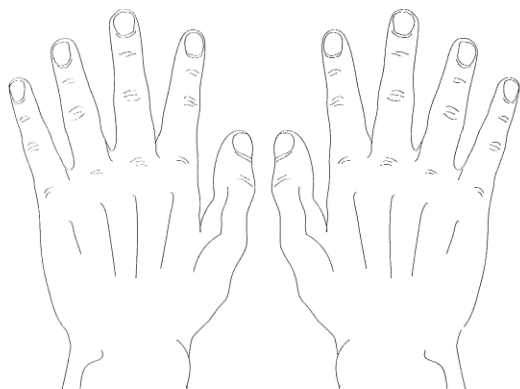
What makes your pain **worse**? _____

What makes your pain **better**? _____

Medications used for this problem: _____

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

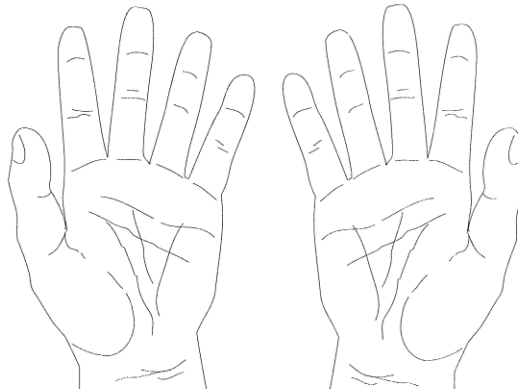
Please indicate the location(s) of your pain with an X:



Left

Back of the Hands

Right



Left

Palm of the Hands

Right

Name _____

Date: _____

Do you have numbness or tingling? Yes / No Where? _____

Do you have swelling? Yes / No Where? _____

Do you have popping / catching / grinding ?

Do you have weakness of grip? Yes / No

Do you have neck pain? Yes / No

Have you had any surgery on this area? Yes / No

Do you have any other problems not previously described? Yes / No

Please describe: _____

Referring Physician: _____

Other Physician you have seen for this problem: _____

Dates of work/school missed for this problem: _____

Is there an attorney involved with this problem? If yes, please provide additional information.

Patient Name: _____

Patient Signature: _____

Date: _____