## ARM QUESTIONNAIRE

PATIE	PATIENT NAME:						DATE OF BIRTH:									
CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):																
1	WHIC	WHICH ARM IS BOTHERING YOU?										RIGH	<u>IT</u>		LEI	FT
2	ON A SCALE OF 0-10 (10 IS THE WORST) HOW SEVERE IS YOUR PAIN? 0 1 2 3 4 5 6 7 8 9 10															
3	WHAT KIND OF PAIN ARE YOU HAVING?															
	YES		NO SHARP				NO	THROBBING								
	YES	NO	NO DULL				NO	ACHING								
	YES	NO	STABBING	YES	NO	BURNING										
4	DO YOU HAVE?															
		YES NO NUMBNESS			YES	NO	SWELLING									
	YES	YES NO TINGLING														
	YES	NO	WEAKNESS													
5	THE P	THE PAIN IS NOW? 6					OUR F	AIN?								
	YES	YES NO CONSTANT				YES	NO	WAK	(E YO	U FR	MC	YOUR S	LEE	P		
	YES	NO	COMES AND GOES			YES	NO	KEEF	YOU	J FRO	M S	LEEPIN	G			
7	SINCE MY PROBLEM STARTED , IT IS?															
	BE	BETTER WORSE UNCHANGED														
8	WHAT MAKES YOUR SYMPTOMS WORSE?															
	DR	DRIVING TYPING SLEEPING				EXERCISE LIFTING				RI	REPETITIVE USE					
						Other										
9	WHAT MAKES YOUR SYMPTOMS BETTER?															
	REST	ICE	HEAT	VITAMIN B6	PHYSI	HYSICAL THERAPY Other										
10	YES	NO	HAVE YOU INJURED TH	INJURED THIS ARM BEFORE?												
	IF YES	IF YES, WHEN?														
11	1 YES NO HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM?															
	IF YES, USE CHECK BOXES BELOW TO DESCRIBE TREATMENTS:															
	TREATMENT DID IT			HELP? TREATME				ENT	T DID IT HELP?							
	ANTI-INFLAMMATORIES			YES	NO		INJECTION				YES NO					
	SLING	i			YES	NO		SUR	GERY	,				YE:	s	NO
	PHYSI	CAL/O	CCUPATIONAL THERAPY		YES	NO		NAR	COTI	CS				YE:	s	NO
	ном	EEXER	CISE PROGRAM		YES	NO		CAS	Γ					YE:	s	NO
12	IF YOU HAVE HAD SURGERY ON YOUR ARM BEFORE, WHEN DID YOU HAVE IT?															
13	YES NO WERE YOU SEEN IN THE EMERGENCY ROOM FOR THIS PROBLEM?															
	IF YES, WHICH EMERGENCY ROOM?															
14	WHAT	WHAT TESTS HAVE YOU HAD FOR THIS PROBLEM?														
15	IF YOU HAVE HAD X-RAYS,CAT SCAN, OR AN MRI, WHERE WERE THEY TAKEN?															

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16	PLEAS	E CIRC	CLE IF THERE ARE ANY NE	W PROBLEMS SIN	ICE YOUR LAST	VISIT:						
	EARS		NERVES	HEART	LUNGS	JOINTS	BOWELS					
	EYES		DIABETES	URINE	SKIN	Other						
	IF AN	Y ARE	CIRCLED PLEASE DESCRIE	BE:								
17	YES	NO	HAVE YOU DEVELOPED	O ANY NEW ALLER	GIES?							
18	YES	NO	HAVE YOU STARTED O	D OR STOPPED SMOKING?								
19	YES	NO	HAVE YOU BEEN PRES	N PRESCRIBED ANY NEW MEDICATION BY ANY OTHER PHYSICIAN?								
20	YES	NO	HAVE YOU BEEN HOSPITALIZED FOR NON-ORTHOPEDIC CONDITION?									
	IF YES	IF YES, PLEASE DESCRIBE?										
21	WHAT IS YOUR CURRENT JOB STATUS?											
	REG	ULAR	LIGHT DUTY	NOT WORKING D	UE TO THIS CO	NDITION						
	DO NOT WORK STUDENT											
22	IF YOU	J HAV	E STOPPED WORKING DU	JE TO YOUR INJUR	Y, WHEN WAS	THE LAST DAY YOU WOR	KED?					
ARE	THERE	ANY C	QUESTIONS YOU WOULD	LIKE ANSWERED A	AT THIS TIME?							
I cert	ifv tha	t I hav	e read and understand t	he above informat	tion to the best	of my knowledge, and t	hat the above questions					
	-						us to my health. I authorize					
	•		•			•	or examination rendered to					
			•				bay directly to the physician					
			s otherwise payable to n to be responsible for pay		•							
SCIVI	CC3. 1 (	agree	to be responsible for pay	intent of an service	es rendered on	my benan or my depend	dents.					
	nt's Si			MD/DA Signatu								
Patient's Signature			е	MD/PA Signature			Date					
Reca	II Revie	w Sig	natures:			Date:						
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