ARM QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which arm(s) did you hurt?_ _____
2.) Is this a new presentation of arm pain, or a follow-up?_____
3.) Did another provider refer you? If yes, who?_____

4.) What is your hand dominance?

__ambidextrous __left hand dominant __right hand dominant __no dominance

5.) Describe **how** and **where** your symptoms occurred/how you injured your arm? Be specific (include **dates)**

_____

_____

6.) What best describes your arm pain? (check all that apply)

__aching	__diminishing	__pins and needles	__tender to touch
__acute	__dull	__popping	__throbbing
__burning	__electric	__progressive	__worsening
__catching	__giving way	__radiating	other:_____
__clicking	__gradual	__sharp	
__constant	__improving	__stabbing	
__cramp-like	__intermittent	__staying the same	

7.) What is associated with your arm pain? (check all that apply)

__arm swelling	__elbow stiffness	__limited ROM of elbow	other:_____
__bruising	__elbow swelling	__limited ROM of shoulder	
__cramping	__hand numbness	__shoulder stiffness	

8.) Describe the timing of your pain? (check all that apply)

__began today	__occurs episodically	__occurs randomly	other:_____
__constantly occurs	__occurs in the morning	__occurs with activity	
__occurs at night	__occurs intermittently	__occurs with weight bearing	

9.) What aggravates or alleviates your arm pain? (check all that apply)

__improves with elevation	__worsens with dependent positioning	other:_____
__improves with rest	__worsens with lifting	
__improves with stretching	__worsens with overhead activity	

10.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___ /10 on a bad day ___ /10 on an average day ___ /10

initially ___ /10 on a good day ___ /10

11.) How long have you had your arm pain? ___years ___months ___weeks ___days

12.) What are you currently using to treat the arm pain? (circle all that apply)

__accupuncture
__activity modification
__brace
__compression stockings
__lidocaine patches
__massage therapy
__muscle relaxants
__narcotics/pain meds
__anti-inflammatory meds
__physical therapy
__sling
__splint
__topical cream
__Tylenol
__no treatment
other:_____

13.) Have you had any procedures or surgeries to treat the arm pain? If yes, what type?

_____

14.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__CT scan
__MRI
__plain radiographs (X-rays)
__no imaging studies
other:_____

15.) How has this problem limited you? (check all that apply)

__attending school on a limited basis
__difficulty with ADL's
__difficulty with REC sports participation
__functional limitations
__inability to go to school
__inability to perform ADL's
__inability to work
__requiring constant assistance
__requiring occasional assistance
__working light duty
__working on a limited basis
__no limitations
other:_____

16.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:_____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date

Recall Review Signatures:

			Date:
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____