ELBOW QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which elbow(s) did you hurt? _____

2.) Is this a new presentation of elbow 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 elbow? Be specific (include **dates)**

_____

_____

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

__aching	__burning	__improving	__worse with elbow extension
__acute	__chronic	__intermittent	__worse with elbow flexion
__acute on chronic	__constant	__progressive	__worse with forearm rotation
__catching	__cramp-like	__radiating	__worse with lifting heavy objects
__clicking	__diminishing	__sharp	__worse with overhead activity
__giving way of the elbow	__dull	__stabbing	__worsening
__pins and needles	__electric	__staying the same	other:_____
__popping	__gradually improving	__tender to touch	
__pressure-like sensations	__gradually worsening	__throbbing	

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

__arm weakness	__elbow swelling	__limited ROM of elbow	__wrist stiffness
__elbow instability	__hand numbness	__weak grip strength	__wrist weakness
__elbow stiffness	__hand tingling	__wrist pain	other:_____

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

__began today	__worse at/during the night	__worse in the morning
__exacerbated by activity	__worse during the day	other:_____

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

__improves with physical therapy	__worsens with bending	__worsens with lifting
__improves with rest	__worsens with exercise	__worsens with movement
__improves with stretching	__worsens with extension	other:_____

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 elbow pain? ___years ___months ___weeks ___days

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

__activity modification __muscle relaxants __sling other:_____
__brace __narcotics/pain meds __splint
__injections __ anti-inflammatory meds __topical cream
__Lidocaine patches __physical therapy __Tylenol

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

_____

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

__MRI __ultrasound other:_____
__plain radiographs (X-ray) __no imaging studies

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

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

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:
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2		
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