HAND QUESTIONNAIRE

Patient Name: _____ DOB: _____

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

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

_____

_____

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

__aching	__popping	__dull	__radiating
__acute	__pressure	__electric	__sharp
__acute on chronic	__swelling	__gradual	__stabbing
__burning	__throbbing	__improving	__staying the same
__catching	__chronic	__intermittent	__tender to touch
__clicking	__constant	__morning pain	__worse with finger movement
__grinding	__cramp-like	__night pain	__worsening
__pins and needles	__diminishing	__progressive	other:_____

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

__a laceration	__bruising	__hand swelling
__a tendon injury	__finger numbness	__wrist pain
__an abrasion	__finger tingling	other:_____

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

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

9.) What aggravates or alleviates your hand 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 hand pain? ___years ___months ___weeks ___days

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

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

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

_____

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

__CT scan __plain radiographs (X-ray) other:_____
__MRI __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:

1			
2			
3			
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