

WRIST QUESTIONNAIRE

Patient Name: _____

DOB: _____

- 1.) Which wrist(s) did you hurt? _____
- 2.) Is this a new presentation of wrist 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 wrist? Be specific (include **dates**)

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

- | | | | |
|---|--------------------------------------|---|---|
| <input type="checkbox"/> aching | <input type="checkbox"/> cramp-like | <input type="checkbox"/> intermittent | <input type="checkbox"/> sharp |
| <input type="checkbox"/> acute | <input type="checkbox"/> diminishing | <input type="checkbox"/> morning pain | <input type="checkbox"/> stabbing |
| <input type="checkbox"/> acute on chronic | <input type="checkbox"/> dull | <input type="checkbox"/> night pain | <input type="checkbox"/> staying the same |
| <input type="checkbox"/> burning | <input type="checkbox"/> electric | <input type="checkbox"/> pins and needles | <input type="checkbox"/> swelling |
| <input type="checkbox"/> catching | <input type="checkbox"/> giving way | <input type="checkbox"/> popping | <input type="checkbox"/> tender to touch |
| <input type="checkbox"/> chronic | <input type="checkbox"/> gradual | <input type="checkbox"/> pressure | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> clicking | <input type="checkbox"/> grinding | <input type="checkbox"/> progressive | <input type="checkbox"/> worsening |
| <input type="checkbox"/> constant | <input type="checkbox"/> improving | <input type="checkbox"/> radiating | other: _____ |

7.) What is associated with your wrist pain/what symptoms do you have? (check all that apply)

- | | | | |
|--|---|---|--------------|
| <input type="checkbox"/> elbow pain | <input type="checkbox"/> hand swelling | <input type="checkbox"/> shoulder pain | other: _____ |
| <input type="checkbox"/> finger numbness | <input type="checkbox"/> hand weakness | <input type="checkbox"/> worse with finger movement | |
| <input type="checkbox"/> finger tingling | <input type="checkbox"/> limited ROM at wrist | <input type="checkbox"/> worse with wrist movement | |

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

- | | | |
|--|--|--|
| <input type="checkbox"/> began today | <input type="checkbox"/> occurs episodically | <input type="checkbox"/> occurs randomly |
| <input type="checkbox"/> constantly occurs | <input type="checkbox"/> occurs in the morning | <input type="checkbox"/> occurs activity |
| <input type="checkbox"/> occurs at night | <input type="checkbox"/> occurs intermittently | other: _____ |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> improves with pain medication | <input type="checkbox"/> worsens with bending | <input type="checkbox"/> worsens with movement |
| <input type="checkbox"/> improves with physical therapy | <input type="checkbox"/> worsens with exercise | other: _____ |
| <input type="checkbox"/> improves with rest | <input type="checkbox"/> worsens with extension | |
| <input type="checkbox"/> improves with stretching | <input type="checkbox"/> worsens with lifting | |

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 wrist pain? ___years ___months ___weeks ___days

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

- aspiration muscle relaxants splint other: _____
- brace narcotics/pain meds topical cream
- cast anti-inflammatory meds Tylenol
- injections physical therapy no treatment

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

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

- bone scan EMG/nerve conduction study plain radiographs (X-ray) other: _____
- CT scan 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 accurately 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 practitioners. 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 _____	_____	_____