COMPREHENSIVE CARPAL TUNNEL QUESTIONNAIRE

Name: ____ Date: ______________

This questionnaire has been designed to assist in the evaluation of your upper extremity problem. Please mark where indicated and fill in the blanks to the best of your ability. There will be time to discuss your symptoms in detail during the consultation.

1. Which hand is affected?

left right both (If both, which is worse?) left right

Are you:

left handed right handed

2. Current symptoms

Intensity: …………………… mild nuisance moderate severe

Frequency: …………………. intermittent (mostly every day? day? night?) constant

Strength: …………………… unaffected weak grip drops objects

Sensation: ………………….. numbness tingling

Fingers affected: …………… thumb index long ring little

3. Previous treatment: ……….. no yes

If yes, How long? Did it help?

Splints/brace ……………. ________________________ ________________________

Medication …………….. ________________________ ________________________

Cortisone inj. ……........... ________________________ ________________________

Physical therapy…………. ________________________ ________________________

Prior CTS surgery……….. ________________________ ________________________

Recent test: …………………... EMG/NCS blood x-ray

4. Work History:

Employer: ____

Job description: ____

Strenuous? _________________________ Describe: (weight) ______________________________

Repetitious? ________________________ Describe: (cycles/min.) __________________________

How long at present position? __________ Injury report filed? ____________ Date filed? __________

Currently working? _________ Regular duty Restricted duty, please explain below

____

If not working, what is the last date of work? ________________

<u>Office Use Only:</u>

JAMAR

Grip	R	L
I		
III		
V		

PINCH METER

	R	L
TIP		
KEY		