

Name: \_\_\_\_\_ Upper Extremity Concern: DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Describe your primary condition: \_\_\_\_\_

When did this begin? \_\_\_\_\_ How did it begin? \_\_\_\_\_ Is this a recurrence?  Y  N

How has it changed since last episode / last exam ?  N/A  Same  \_\_\_\_\_ % Better  \_\_\_\_\_ % Worse

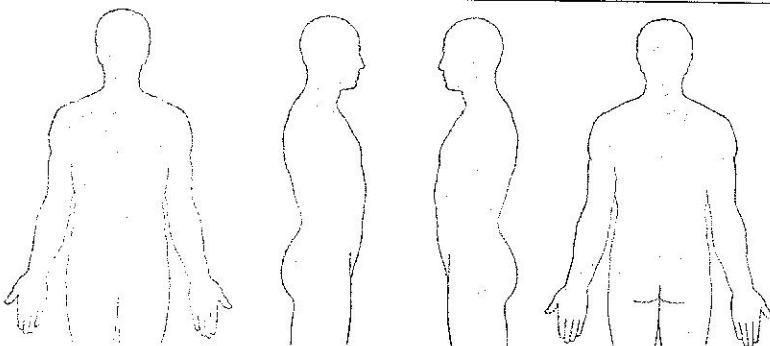
How frequently are you affected by this condition?  Constant  Daily  Intermittent  Morning Only  Night Only

After a specific activity  During a specific activity Describe: \_\_\_\_\_

What makes it worse?

What makes it better? And for how long?

Please rate your ability to do the following in this last week	Difficulty:	No	Mild	Moderate	Severe	Unable
Open a tight or new jar		1	2	3	4	5
Write		1	2	3	4	5
Turn a key.		1	2	3	4	5
Prepare a meal.		1	2	3	4	5
Push open a heavy door.		1	2	3	4	5
Place an object on a shelf above your head.		1	2	3	4	5
Do heavy household chores (e.g., wash walls, wash floors).		1	2	3	4	5
Garden or do yard work.		1	2	3	4	5
Make a bed.		1	2	3	4	5
Carry a shopping bag or briefcase.		1	2	3	4	5
Carry a heavy object (over 10 lbs).		1	2	3	4	5
Change a lightbulb overhead.		1	2	3	4	5
Wash or blow dry your hair.		1	2	3	4	5
Wash your back.		1	2	3	4	5
Put on a pullover sweater.		1	2	3	4	5
Use a knife to cut food.		1	2	3	4	5
Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).		1	2	3	4	5
Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).		1	2	3	4	5
Recreational activities in which you move your arm freely (e.g., playing frisbee, etc.).		1	2	3	4	5
Manage transportation needs (getting from one place to another).		1	2	3	4	5
Sexual activities.		1	2	3	4	5
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?		1	2	3	4	5
<b>Rating Interference/Limitation</b>		<b>Not at all</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Severely</b>
During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?		1	2	3	4	5
During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?		1	2	3	4	5
<b>Please rate the severity of the following symptoms in the last week.</b>		<b>No</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
Arm, shoulder or hand pain.		1	2	3	4	5
Arm, shoulder or hand pain when you performed any specific activity.		1	2	3	4	5
Tingling (pins and needles) in your arm, shoulder or hand.		1	2	3	4	5
Weakness in your arm, shoulder or hand.		1	2	3	4	5
Stiffness in your arm, shoulder or hand.		1	2	3	4	5
I feel less capable, confident or less useful because of my arm, shoulder or hand problem.		<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>



Mark the areas of pain on this diagram.

Identify: S = Sharp A = Ache B = Burn W = Weak  
N = Numb D = Dull T = Tingling

Additional Patient Comments: \_\_\_\_\_