

Name _____

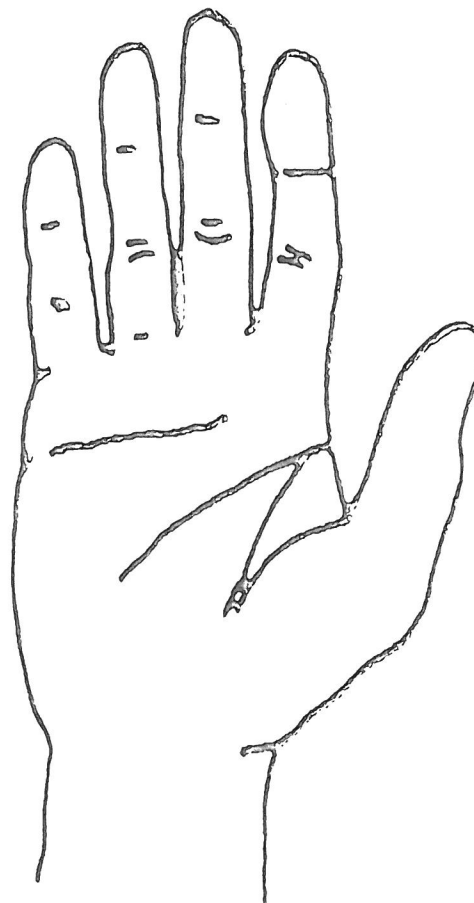
1. Are You: (Circle One) Right Handed Left Handed
2. Which hand are you coming in to have evaluated? (Circle One) Right / Left

3. Onset of Problem: (Circle One)
- Gradually Since _____
- Suddenly One _____
- Vehicle Accident _____
- Injury, One _____
- Injury While Playing Sports, On _____
- Injury At Work, On _____
- Don't Know _____

4. Frequency of Pain:
- _____ None
- _____ Occasionally
- _____ Constantly
- _____ Recent Onset
- _____ With Activity
- _____ Even When Resting

5. Time of day when pain occurs:
- _____ Morning
- _____ All Day
- _____ Mainly at Night
- _____ All Day and Night

6. Pain relieved by:
- _____ Nothing
- _____ Rest
- _____ Activity
- _____ Splint
- _____ Medicine - If so, What Kind _____



7. Do your fingers or thumb feel as if they have fallen asleep? (Circle all that apply)
- NO / YES If so, which Ones: INDEX MIDDLE RING SMALL THUMB