

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? _____

Office Use Only:

JAMAR

Grip	R	L
I		
III		
V		

PINCH METER

	R	L
TIP		
KEY		