

WRIST QUESTIONNAIRE

Advanced Sportsmedicine Center

1. FULL NAME: _____ AGE: _____ TODAY'S DATE: ___/___/___

2. Which WRIST bothers you? RIGHT LEFT BOTH

3. When was the **first time** you ever had symptoms? _____

4. When did your **present** problem begin? _____ How did it occur? _____

5. What is your dominant hand? RIGHT LEFT

6. Have you had prior **right** wrist injuries? YES NO If so, when & what? _____

7. Have you had prior **left** wrist injuries? YES NO If so, when & what? _____

8. What part of your wrist hurts? TOP BOTTOM PALM THUMB SIDE PINKY SIDE JOINT

9. Do you have lumps or masses? YES NO If so where? _____

10. Is dexterity (fine control of fingers) limited? YES NO

11. Do you have pain while trying to sleep at night? YES NO

12. What causes wrist pain?

REPETITIVE MOTION GRIPPING CHANGES IN WEATHER LIFTING WEIGHT
OVERHEAD POSITIONING THUMB MOTION OTHER _____

13. My wrist pain is now getting: WORSE BETTER STAYING THE SAME

14. My wrist: POPS LOCKS SWELLS DOES NONE OF THESE

15. My arm/hands/fingers have: LOSS OF SENSATION TINGLING NONE OF THESE
If so, location: _____

16. Are activities of daily living limited? YES NO
If so, please list activities UNABLE to perform: _____

17. Have you had wrist X-rays? YES NO If so, when & where? _____

18. Have you had a wrist MRI? YES NO If so, when & where? _____

19. Has a doctor evaluated your wrist? YES NO If so, whom? _____

20. Check any wrist treatments you have tried before today:

ICE HEAT REST SPLINT ACE WRAP MSM HERBAL REMEDIES INJECTIONS
HOME REHAB/EXERCISES PHYSICAL THERAPY GLUCOSAMINE CHONDROITIN
MEDICATIONS (Please list) _____

WHICH TREATMENTS HAVE HELPED? _____