HAND EVALUATION FORM

Name ________________________________________________  Date________________________

1. Which hand(s)/wrist(s) are we seeing you for? □ R    □ L    □ Both

2. Did you injure the hand/wrist? □ Yes □ No □ Gradual onset of symptoms

3. Date of injury or approximate date of gradual onset of symptoms: ___________________________

4. Have you had any previous treatment for this condition? □ Yes □ No
   If Yes, who treated you? ______________________________________________
   Date of initial treatment: ______________________________________________
   Type of treatment: medication? □ Yes □ No
   If Yes, name(s) of medication: __________________________________________

   Splinting? □ Yes □ No
   Therapy? □ Yes □ No
   Work Modification? □ Yes □ No

   Approximate duration of above treatment: __________________________________________

5. Have you experienced any of the following problems? (please answer Yes or No)
   Pain In the hand_____ wrist_____ arm_____ shoulder_____ 
   Swelling In the hand_____ wrist_____ arm_____ shoulder_____ 
   Stiffness In the hand_____ wrist_____ arm_____ shoulder_____ 
   Numbness In the hand_____ wrist_____ arm_____ shoulder_____ 
   Tingling In the hand_____ wrist_____ arm_____ shoulder_____ 
   Do you experience pain at night? □ Yes □ No
   Do you experience numbness at night? □ Yes □ No

6. Does the hand ever become discolored (blue or red)? □ Yes □ No