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