



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