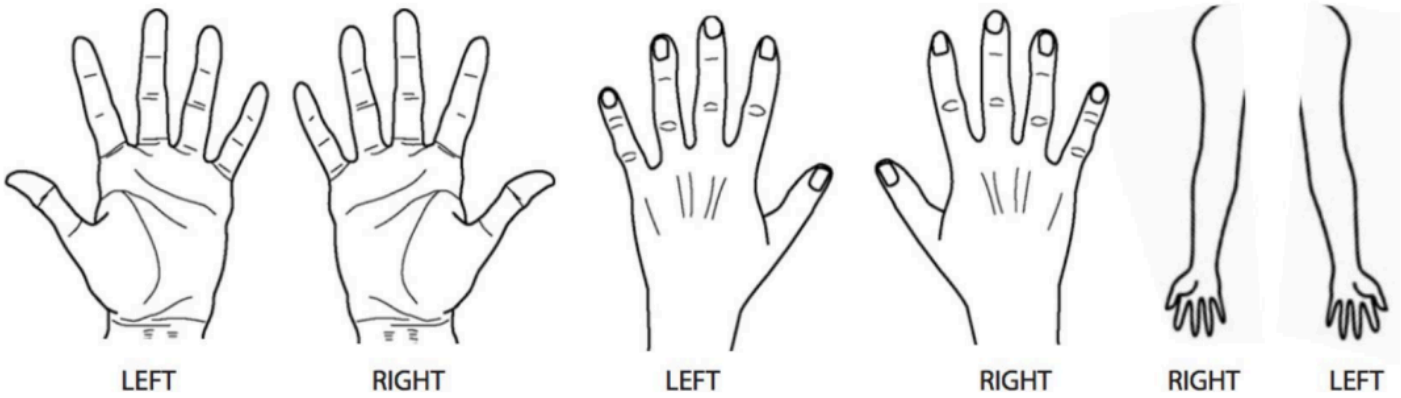
# Hand to Shoulder Questionnaire

Today's Date _____
First Name _____ Last Name _____
Date of Birth _____ Occupation _____
Gender: ☐ Male ☐ Female Height _____ Weight _____

**History**

Which hand do you write with? ☐ Right ☐ Left ☐ Ambidextrous
Which side is causing concern? ☐ Right ☐ Left ☐ Both (If both, which is worse?) ☐ Right ☐ Left
What is the main problem that brought you in to see the doctor today? _____
_____
How long have you had symptoms, or when were you injured? _____
_____
Is this a work-related injury? ☐ Yes ☐ No Employer: _____
Rank the severity of your symptoms: ☐ Mild ☐ Moderate ☐ Severe
Timing: ☐ On-and-off ☐ Constant ☐ Morning ☐ Nighttime
Describe your quality of pain: ☐ Dull ☐ Throbbing ☐ Sharp ☐ Burning ☐ Numbness ☐ Tingling ☐ Ache
☐ Other: _____
Hobbies or sports: _____

**Please use the diagram to mark the problem areas:**




**Treatment and Medications**

What makes your symptoms better? _____
What makes your symptoms worse? _____
Please list any prior treatment you have had for this problem, and whether it has helped.

Medications (Type): _____
Splints (Type, Wear day / night / both): _____
Injections (Dates, Location): _____
Surgery (Dates, Description): _____
Other: _____

How did you find out about us? _____