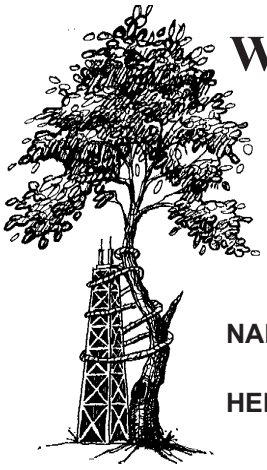


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue Chicago, Illinois 60659
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

TODAY'S DATE _____/_____/_____

PATIENT INFORMATION QUESTIONNAIRE: WRIST/HAND/FINGERS

NAME _____
FIRST MIDDLE LAST

HEIGHT _____ **WEIGHT** _____ **AGE** _____

I AM RIGHT HANDED **I AM LEFT HANDED** (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction Desk Job Driving Teacher

Executive/Professional Factory Homemaker Retired Sales Student

Other (Please List) _____

IF YOU ARE <u>NOT</u> WORKING NOW, WHEN DID YOU LAST WORK? _____/_____/_____

DOES IT REQUIRE LIFTING? **HOW OFTEN DO YOU LIFT THESE WEIGHTS?** (Please Circle)

None 10 lbs. or less 10-50 lbs. 50-100 lbs More than 100 lbs.

Rarely Frequently Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)

Grasp Push Pull Type Use Tools Manipulate Small Objects Write Carry things

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle) Yes No

Company Name _____ Company Phone (_____)_____

Company Address _____
STREET CITY STATE ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle) Yes No

Lawyer's Name _____ Lawyer's Phone (_____)_____

Lawyer's Address _____
STREET CITY STATE ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)

Right: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes

Left: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes

Back Neck Other (Please List) _____

_____

PLEASE <u>CIRCLE</u> YOUR <u>ONE MAJOR</u> COMPLAINT ! PLEASE <u>CHECK</u> (✔) ANY OTHER COMPLAINTS

Shooting pains ("Burners)"	Elbow/Forerm Pain	Wrist/Hand Pain
Deformity of hand/fingers	Instability/Popping Out	Loss of Sensation
Grinding/Popping/Snapping	Something Moving Inside	Driving/Sitting
Locking/Catching	Aching/Soreness	Numbness/Tingling/Burners
Weak Grasp/Pinch	Swelling	Clumsiness/Poor coordination
Stiffness	A Mass/Tumor/Cyst	Limited Activities/Work

Difficulty With: Eating Lifting Personal Hygiene Writing/Typing Using Tools Opening a Tight Jar/Doorknob

Picking up Small Objects Loss of Motion Stiffness in AM PM Fingers Turning Blue or Colors

Any Other Complaints_____

HAVE YOU EVER HAD A WRIST/HAND/FINGER INJURY OR PAIN? YES NO (See Last Page for Surgery)

WHEN?_____

_____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

An Injury : On ____/____/___ _____ Days Ago _____ Weeks Ago ____ Months Ago ____ Years Ago

I Don't Know When _____ Gradually Since _____

Other_____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR WRIST/HAND/FINGERS? Yes No

How long have you been off work? ____ days ____weeks ____ months _____ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR WRIST/HAND/FINGERS? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling	Hit By Object	Throwing
Hit By Another Player	Lifting	Tripping
Noncontact	Pulling/Pushing	Reaching
Twisting	Vehicle Accident	Cut by a Knife/Glass/Piece of Metal/Saw

Other_____

_____

INJURED DURING:(Please Circle)

Aerobics	Basketball	Baseball
Bicycling	Football	Handball
Racquetball	Running	Soccer
Skiing	Tennis	Volleyball

Other _____

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On _____ Time of Day _____ AM PM

Was any equipment, machinery and/or object involved in the accident? **Yes** **No**

If yes,please explain._____

_____

Was the accident reported to your supervisor and/ or employer at the time of the injury? **Yes** **No**

IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION

Vehicle Accident On _____/_____/_____ Time of Day _____ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? **Yes** **No**

Did you strike your head or lose consciousness? **Yes** **No**

If you were passenger,what was your position in the vehicle? _____

_

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other _____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other _____

_____

Was your vehicle moving when it was struck? **Yes** **No** How fast was it going? _____

Was the accident reported to the police? **Yes** **No**

What was the weather? _____

Did your vehicle strike another vehicle or object? **Yes** **No** Please Describe:_____

Other _____

_____

_____

IF YOU ARE EXPERIENCING **PAIN**: PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have _____% Good Days _____ % Bad Days _____ % Average Days

LOCATION OF THE PAIN (Please Circle The Major Pain and Check (✔) Any OthersThat Apply)

Forearm Palm of the Wrist/Hand Back of the Wrist/Hand
All Over Deep Inside
Top of the Bottom of the !st 2nd 3rd 4th 5th Finger All Fingers

THE PAIN GOES TO: (Please Circle All Those That Apply)

Between My Shoulder Blades Arm Elbow Fingers
Back of the Hand Palm of the Hand To the Fingers

WHERE DID YOUR PAIN START? _____

WHERE DID YOUR PAIN SPREAD?(If Anywhere) _____

HAVE YOU EVER HAD WRIST/HAND/FINGERS PAIN BEFORE? Yes No

WHEN?_____

FREQUENCY OF PAIN: (Please Circle All Those That Apply)

Recent Onset	Occassionally	Irregularly
Unpredictable	Some Days	Most/ Every Day
Constantly	At Work	Most/Every Night
Even When Resting	With or After Activity/Sports	Initially But Not Now
Getting More Frequent	Getting Less Frequent	Frequency is Unchanged

Other _____

TIME OF DAY WHEN THE PAIN OCCURS: (Please Circle The MajorTime of Day and Check (✔) Any OthersThat Apply)

Morning	Late in the Day	Evening
Unpredictable	Irregular	Good & Bad Days
At Work	All Day/Constant	No Apparent Pattern to the Pains
Interrupts My Sleep	Other _____	

HOW OFTEN DOES THE WRIST/HAND/FINGER PAIN WAKE YOU UP OR KEEP YOU FROM GOING TO SLEEP?

Never Rarely Some Nights Most Nights Every Night
I Can Sleep But Only When I Take Medicine I Can't Sleep Even When I Take Medicine

THE PAIN IS:

Sharp/Knifelike	Dull	Aching
Electric Shock	Burning	Continuous
Worse in the Morning	Worse in the Evening	Soreness but not pain

Other _____

PAIN MADE WORSE WHEN:(Please Circle All Those That Apply)

Carrying Objects	Eating	Combing/Washing My Hair
Dressing	Driving or Sitting	Fastening a Bra
Opening a Jar	Pulling on Pants or Skirt	Pushing
Reaching Back	Reaching Out	Personal Hygiene
Turning a Key	Resting	Throwing
Using Tools	With Any Movement	Problems with prolonged bending of elbow/wrist
Weather Changes	Writing or Typing	Going into My Back Pocket/Tucking in My Shirt

Difficulty with: Picking up Small Objects Playing a Musical Instument Coordination Tieing Shoelaces

Other _____

PAIN RELIEVED BY: (Please Circle All Those That Apply)

Nothing	Rest	Activity
Moving the Wrist/Hand/Fingrs	Heat	Ice
Medicine	Cortisone Injection	Physical Therapy

Other _____

WRIST/FINGER RANGE OF MOTION: (Please Circle All those That Apply)

Normal Can't Lift Wrist Up Can't Bend Wrist Down
Can't Straighten Fingers/Thumb Can't Bend Fingers/Thumb
I Can't Grab a: Carton of Milk Glass A Tube of Toothpaste A Pencil/Pen

DO YOU HAVE PAIN WITH LIFTING:

	TO EYE LEVEL		OVERHEAD	
Weight of Arm Only	Yes	No	Yes	No
Telephone Book or 1 Pint of Milk (1-2 lbs.)	Yes	No	Yes	No
Sack of Flour or 1 Gallon of Milk (5-10 lbs.)	Yes	No	Yes	No
A Small Child (25-50 lbs.)	Yes	No	Yes	No
50-100 lbs.	Yes	No	Yes	No
More Than 100 lbs	Yes	No	Yes	No

ACTIVITIES YOU ABSOLUTELY CAN NOT DO BECAUSE OF THE WRIST/HAND/FINGERS: (Please Circle All those That Apply)

None	Sleep	Typing/Writing
Put on Shoes/Socks	Shopping	Housework
Yardwork	Eat Or Feed Myself	Reading
Cut My Food	Use Tools	Open a Tight Jar/Doorknob

Recreational activities I enjoy (Please List) _____

BECAUSE OF MY WRIST/HAND/FINGER PAIN, I HAVE TO SLEEP : (Please Circle)

On My Back	On The Side of The Unaffected Shoulder
On My Stomach	On the Side of the Affected Shoulder
Sitting Up	Affected Arm Up, Shoulder Between My Head and Mattress
Affected Arm At my Side	I Have No Difficulty Sleeping

WHICH SPORTS MAKE THE PAIN WORSE? (Please List) _____

_____

NONPAIN SYMPTOMS/COMPLAINTS

MAXIMUM WEIGHT YOU CAN PUSH/PULL: None 25-50 lbs. 100 lbs. More than 100 lbs.

IS YOUR ARM COMFORTABLE AT YOUR SIDE? YES NO

MAXIMUM WEIGHT YOU CAN CARRY: (Please Circle) Weight of the Arm Only
Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

DO YOU FEEL CRUNCHING, POPPING, GRINDING, GRATING OR "FUNNY NOISES"? (Please Circle)
Never Noticeable When Grasping I Can Feel Them I Can Hear Them
Where?_____
ARE THE "NOISES" PAINFUL? YES NO

AT THE TIME OF INJURY, DID YOU FEEL A RIP, POP OR TEARING? YES NO

DO THE WRIST/HAND/FINGERS SWELL? (Please Circle All Those That Apply)

None Ever	Frequently	Originally, But Not Since
Daily	Worst in the AM PM	Doesn't Ever Go Away - Constant
When the Weather is Bad	After Popping Out or Dislocating	Only After Exercise or Use of the Joint

Other_____

DO THE WRIST/HAND/FINGERS GET "STUCK", "CATCH" OR "LOCK UP"? (Please Circle All Those That Apply)
Never Constantly With Grasping
Just Started Frequently Catches But Does Not Truly Lock
Daily ____ Weekly ____ Monthly ____ How Many Total Times? _____

DO YOU HAVE WEAKNESS IN THE WRIST/HAND/FINGERS? YES NO

Where?_____

DO YOU HAVE STIFFNESS IN THE WRIST/HAND/FINGERS? (Please Circle All those That Apply)
None Always After Activity or Sports
When Sitting/Driving In the AM PM

Other _____

DO YOU HAVE NUMBNESS,TINGLING, OR "PINS AND NEEDLES"? (Please Circle All those That Apply)
NONE Constantly At First But Not Now

At Night Where? _____

DO YOU FEEL THAT THE WRIST/HAND/FINGER MUSCLES HAVE "SHRUNKEN" OR ATROPHIED? YES NO

DO YOU HAVE SKIN LESIONS OR PROBLEMS? YES NO

WHERE?_____

HAVE YOU EVER HAD TO USE A SLING OR BRACE? YES NO

HAVE YOU EVER RUPTURED YOUR BICEPS TENDON? YES NO If so, when? _____

HAVE YOU EVER BROKEN A BONE? (Please List and Date Each) _____

_____

HAVE YOU EVER DISLOCATED ANOTHER JOINT?(Please List and Date Each)

_____

_____

WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN?ARE LIMITED IN THEM?(Please List)

_____

HAVE YOU OR DO YOU PARTICIPATE IN **COMPETITIVE** SPORTS AND AT WHAT LEVEL? (Please List)

_____

HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN? **NO**

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Darvocet-N-100(propoxyphene)	Motrin/Ibuprofen/Advil	Daypro(oxaprozin)	Dantrium(dantrolene)
Tylenol #3 (codeine)	Aspirin	Clinoril (sulindac)	Flexeril (cyclobenzaprene)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Skelaxin(metaxalone)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Robaxin(methocabamol)
Tylenol (acetaminophen)	Voltaren(diclofenac)	Relafin(nabumetone)	Neurontin (gabapentin)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Lyrica(pregabalin)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other _____

Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? _____

DOES THE MEDICATION HELP? Yes No Only A Little Bit

PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED

0 1-2 3-4 5-6 7-8 9-10

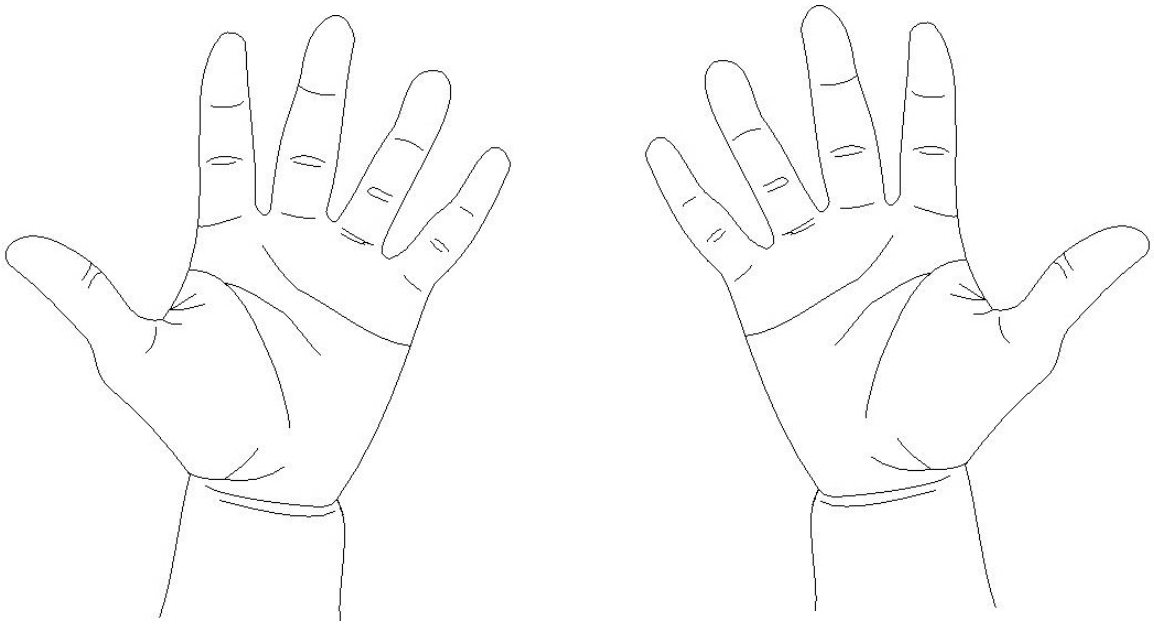
0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

How bad is your pain **today?**	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the **worst its ever been?**	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the **best its ever been?**	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your **lifestyle?**	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your **work?**	0	1	2	3	4	5	6	7	8	9	10
Do you have pain **lying in bed or at rest?**	0	1	2	3	4	5	6	7	8	9	10

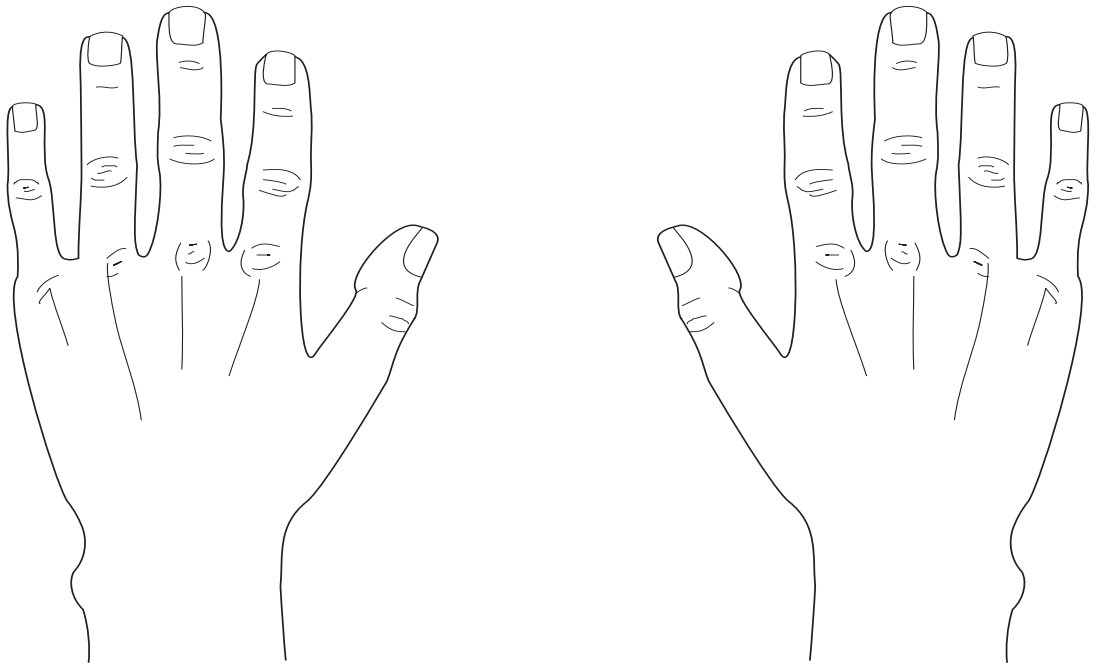
PLEASE DIAGRAM THE AREAS OF YOUR PAIN OR SYMPTOMS:

Burning [XXXX] Throbbing [✔✔✔✔] Sharp [////////] Aching [●●●●●] Numbness [✻✻✻✻]

LEFT PALM OF THE HAND RIGHT



LEFT RIGHT



BACK OF THE HAND

WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON? YES NO

Name _____ When _____

Diagnosis_____ Treatment (See Below)

WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU EVER HAVE X-RAYS TAKEN OF YOUR WRIST/HAND/FINGERS? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE AN ARTHROGRAM (dye test) DONE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE A CAT SCAN OR MRI DONE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD PHYSICAL THERAPY (PT) OR A BRACE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD SURGERY FOR YOUR HAND OR WRIST? YES NO

#1 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#2 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#3 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#4 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

THANK YOU FOR PATIENCE IN FILLING OUT THIS FORM!