UPPER EXTREMITY PAIN QUESTIONNAIRE

Patient Name: ____**Date:** ______________________

Please indicate all areas where you are experiencing pain:

□Upper Arm (Front / Back / Medial / Lateral) □Lower Arm (Front / Back / Medial / Lateral)

□Elbow (Medial / Lateral) □Wrist (Medial / Lateral) □Hand (Top / Bottom)

How long have you had pain?

Is your pain rapidly getting worse? Yes / No

Is your pain secondary to major trauma (car accident, fall from height, sports)? Yes / No
If yes, describe in detail:

Is your pain secondary to minor trauma or repetitive stress from work or sports? Yes / No
If yes, describe in detail:

Do you have a history of cancer or blood clots? If Yes, Describe: Yes / No

Have you recently experienced fever, chills or unexplained weight loss? Yes / No

Have you recently experienced a bacterial infection, IV drug use or immune system suppression from corticosteroids, transplant or HIV? Yes / No

Are you experiencing pain that cannot be made to feel worse or better with any specific movement or position? Yes / No

Is your pain associated with other symptoms in your arms (numbness, tingling, burning, etc.)? Yes / No
Describe in detail:

Is your pain associated with difficulty balancing or gripping? Yes / No

Is your pain associated with changes in neck or shoulder function? Yes / No

Is your pain induced by coughing, sneezing, straining, or bending forward? Yes / No

Is your pain associated with numbness or tingling in your arms or hands? Yes / No

What specifically aggravates your pain?

□Sitting □Standing □Coughing □Sneezing
□Gripping □Lying Down □Walking □Lifting
□Computer Work □Driving Car □Jumping □Stretching
□Bending Forward □Bending Back □Bending to Left □Bending to Right
□Bowel Movements □Pushing / Pulling □Running □Squatting
□Arms overhead □Other, describe:

What specifically alleviates your pain?

□Nothing □Lying Down □Hot Packs □Cold Packs □Massage □Manipulation
□Exercise □Stretching □Traction □Electrical Stimulation □Ultrasound
□Medications, describe:
□Resting in specific position, describe:
□Other, describe:

How would you describe your pain?

□Dull	□Aching	□Burning	□Sharp / Stabbing	□Electrical
□Pins / Needles	□Deep	□Superficial	□Tingling	□Numbing

□Other, describe:

Does your pain spread? Yes / No

If it spreads, where does it start and where does it go?

If it is pin-point pain, where is it?

On a scale of 1 to 10, 1 being very minimal pain and 10 being the worst pain you can imagine, circle how you would rate your pain:

At its best: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

At its worst: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

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

What % of the time do you experience your pain?

Daily: 0%---------------25%---------------50%---------------75%---------------100%

Weekly: 0%---------------25%---------------50%---------------75%---------------100%

Monthly: 0%---------------25%---------------50%---------------75%---------------100%

Does your pain interfere with your ability to:

□Sleep, describe:

□Work, describe:

□Exercise, describe:

□Other, describe:

At what time of the day is your pain at its worst?

At what time of the day is your pain at its best?

Have you experienced this pain before? Yes / No

History of Previous Evaluations / Treatments for Your Pain

Who have you seen previously for your pain? Describe who, when, diagnosis and treatment previously received:

Have you received any special tests previously for your pain i.e. MRI, X-ray? Describe:

Which previous treatment(s) did you find most beneficial?

Which previous treatment did you find least beneficial?

What do you think is causing your pain?