Name: _____ **Account #:** _____

Carpal Tunnel Syndrome Questionnaire

The following questions refer to your symptoms for a typical twenty-four hour period during the past two weeks (circle one answer to each question).

SEVERITY SCALE: 0 = None or Never; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very severe

SYMPTOM SEVERITY SCALE

QUESTION SEVERITY SCORE 0 = None; 4 = Severe	0	1	2	3	4
1. How severe is the hand or wrist pain that you have at night?	0	1	2	3	4
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks (time/night)?	0	1	2	3	4
3. Do you typically have pain in your hand or wrist during the daytime?	0	1	2	3	4
4. How often do you have hand or wrist pain during the daytime (times/day)?	0	1-2	3-5	5+	constant
5. How long, on average, does an episode of pain last during the daytime (in minutes)?	0	<10	10-60	>60	constant
6. Do you have numbness (loss of sensation) in your hand?	0	1	2	3	4
7. Do you have weakness in your hand or wrist?	0	1	2	3	4
8. Do you have tingling sensations in your hand?	0	1	2	3	4
9. How severe is numbness (loss of sensation) or tingling at night?	0	1	2	3	4
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?	0	1	2-3	4-5	5+
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?	0	1	2	3	4

FUNCTIONAL STATUS SCALE

QUESTION SEVERITY SCORE 0 = None; 4 = Severe	0	1	2	3	4
1. Writing	0	1	2	3	4
2. Buttoning of clothes	0	1	2	3	4
3. Holding a book while reading	0	1	2	3	4
4. Gripping of a telephone handle	0	1	2	3	4
5. Opening of jars	0	1	2	3	4
6. Household chores	0	1	2	3	4
7. Carrying of grocery bags	0	1	2	3	4
8. Bathing and Dressing	0	1	2	3	4

Comments:_____

_____

_____

_____

Name: _____ **M/F:** _____ **Age:** _____ **Date:** _____ **DOI:** _____