



GP THERAPY, LLC D.B.A.

GERMANTOWN PHYSICAL THERAPY

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Patient: _____ **Region: Elbow, Wrist, or Hand**

1. Describe your pain (sharp, dull, radiating, etc) _____
2. When and how did it start? _____
3. What makes it better? Worse? _____
4. Have you had other treatment for this condition? If so, what kind? _____
5. Rate your average pain intensity over the past week on the 0 to 10 scale with 10 being the worst pain imaginable. ____/10
6. Average number of times you wake per night due to **elbow, wrist or hand** pain. _____

For questions 7 through 17, circle the number that best describes your level of difficulty with the following activities. 0 indicates no difficulty, whereas 10 indicates the inability to perform the activity at all.

| | No Difficulty | | | | | | | | | | Extreme Difficulty | | | | | | | | | | | |
|--|---------------|---|---|---|---|---|---|---|---|---|--------------------|---|---|---|---|---|---|---|---|---|---|----|
| 7. Personal care (washing, brushing teeth, etc.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Dressing (buttons, zippers, etc.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. Fully extending your elbow when reaching | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 10. Gripping objects | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11. Opening jars | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 12. Turning doorknobs | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 13. Turning a key in a lock | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 14. Operating your vehicle | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 15. Pushing/pulling heavy doors | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 16. Writing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 17. Typing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

18. What is your current occupation? _____

19. Does your pain affect your occupation? If so, how? _____

20. Does your pain affect home life? If so, how? _____

21. Does your pain affect your recreation/leisure/sports? If so, how? _____

Patient's Signature: _____ Date: ____/____/____