STEVEN C. KRONLAGE, MD
Hand & Upper Extremity Surgery
Florida Bone & Joint Specialists

ANDREWS INSTITUTE
PHYSICIAN PROVIDER

Carpal Tunnel Questionnaire

The following questions refer to your symptoms for a typical 24 hour period during the past 2 weeks.

Patient Name: _____ Date: _____

Mark one answer to each symptom.
How severe are the following symptoms in your hands?

	None		Mild		Moderate		Severe		Very Severe	
	LT	RT	LT	RT	LT	RT	LT	RT	LT	RT
Pain at night										
Pain during the day										
Numbness/Tingling at night										
Numbness/Tingling during the day										

How often do the following symptoms in your hands wake you up at night?

	Never		Once		2-3 times		4-5 times		More than 5 times	
	LT	RT	LT	RT	LT	RT	LT	RT	LT	RT
Pain										
Numbness/Tingling										

Based on your symptoms over the last few days (not this moment, in particular) please rate your pain:

0 = No Pain ; 10 = Agonizing Pain

LEFT	0	1	2	3	4	5	6	7	8	9	10
RIGHT	0	1	2	3	4	5	6	7	8	9	10

THE QuickDASH OUTCOME MEASURE

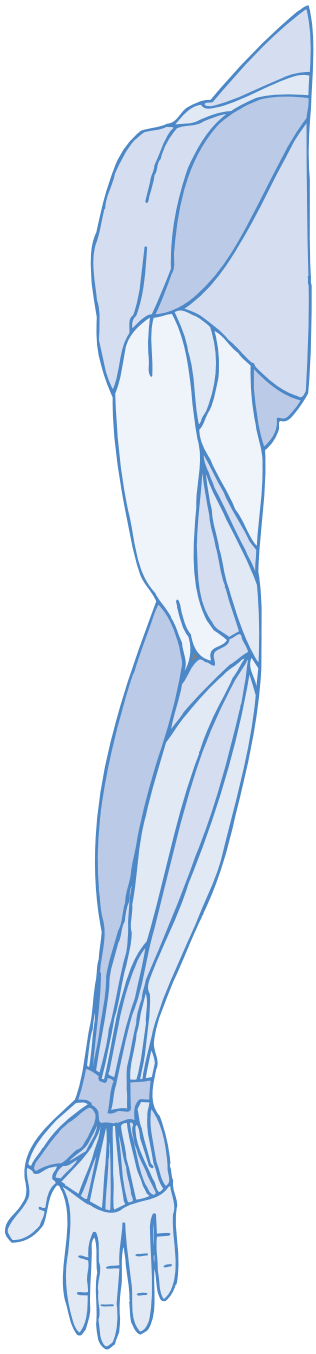
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

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PAIN MEDICATION POLICY

Dear patient:

Florida has joined the majority of other states in our country by implementing opioid reform legislation. Legislation HB 21 applies a 3-7 day cap on the prescribing of Schedule II pain medications for the treatment of pain unrelated to cancer or terminal illness.

Due to this legislation and our commitment to the safety and long term well being of our patients, we have implemented and adhere strictly to the following pain medication policy:

- We only provide pain medications to patients that have undergone surgery by our physician.
- We will only provide post operative pain medication for 1 week after your procedure. Any additional needs for pain control will need to be addressed by your primary care or pain management provider.
- If you are currently taking prescription pain medication provided by another physician, or are under pain management of any kind, WE WILL NOT PROVIDE PAIN MEDICATION AFTER SURGERY. You will need to discuss post operative pain management with the provider that is currently prescribing your pain medications. We are happy to provide documentation of your procedure to you or your physician in advance so that you can plan accordingly.

If you have any questions or concerns regarding this policy, please let us know.

Thank you for allowing us to participate in your care!

I have read and understand the PAIN MEDICATION POLICY outlined above.

_____	_____	_____
Printed Name	Signature	Date