

UPPER EXTREMITY PAIN QUESTIONNAIRE

Complete this section if you experience pain or other symptoms in your fingers, hands, wrists, elbows or shoulders. Check if you do not experience symptoms in these areas_____. Rate the degree to which your symptoms over the past month have negatively affected your ability to perform the following functions. Rate each function.

- SCALE: **0= NOT AT ALL**
- 1-3= SLIGHTLY**
- 4-6= MODERATE**
- 7-10= SEVERE OR GREATLY**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------------|---|---|---|---|---|---|---|---|---|----|
| Dressing | | | | | | | | | | |
| Sleeping | | | | | | | | | | |
| Getting milk jug | | | | | | | | | | |
| Lifting a heavy box | | | | | | | | | | |
| Reaching overhead | | | | | | | | | | |
| Using a hammer | | | | | | | | | | |
| Picking up small objects | | | | | | | | | | |
| Openings jars | | | | | | | | | | |
| Writing | | | | | | | | | | |
| Driving over 30 minutes | | | | | | | | | | |
| Hobbies | | | | | | | | | | |
| Performing your job | | | | | | | | | | |
| Keyboarding | | | | | | | | | | |
| Carrying bags | | | | | | | | | | |
| Grooming | | | | | | | | | | |
| Cooking | | | | | | | | | | |
| Housecleaning | | | | | | | | | | |

COMMENTS: _____

NAME: _____ DATE: _____ AGE: _____