

Industrial Physical Therapy, Inc.

The Carpal Tunnel Questionnaire

Name: _____ Signature: _____ Date: _____

Symptom Severity Scale: The following questions refer to your symptoms for a 24 hour period during the past 2 weeks (circle 1 answer to each question).

1. **How severe is the hand or wrist pain that you have at night?**
 - A. I do not have hand or wrist pain at night
 - B. Mild pain
 - C. Moderate pain
 - D. Severe pain
 - E. Very severe pain
2. **Do you typically have pain in your hand or wrist during the daytime?**
 - A. I never have pain during the day
 - B. I have mild pain during the day
 - C. I have moderate pain during the day
 - D. I have severe pain during the day
 - E. I have very severe pain during the day
3. **How long, on average, does an episode of pain last during the daytime?**
 - A. I never get pain during the day
 - B. Less than 10 minutes
 - C. 10 to 60 minutes
 - D. Greater than 60 minutes
 - E. The pain is constant throughout the day
4. **Do you have weakness in your hand or wrist?**
 - A. No weakness
 - B. Mild weakness
 - C. Moderate weakness
 - D. Severe weakness
 - E. Very severe weakness
5. **How severe is numbness (loss of sensation) or tingling at night?**
 - A. I have no numbness or tingling at night
 - B. Mild
 - C. Moderate
 - D. Severe
 - E. Very severe
6. **Do you have difficulty with the grasping and use of small objects such as keys or pens?**
 - A. No difficulty
 - B. Mild difficulty
 - C. Moderate difficulty
 - D. Severe difficulty
 - E. Very severe difficulty
7. **How often did hand or wrist pain wake you up during a typical night?**
 - A. Never
 - B. Once
 - C. Two or three times
 - D. Four or five items
 - E. More than five times
8. **How often do you have hand or wrist pain during the daytime?**
 - A. Never
 - B. Once or twice a day
 - C. Three to five times a day
 - D. More than five times per day
 - E. The pain is constant
9. **Do you have numbness (loss of sensation) in your hand?**
 - A. No
 - B. I have mild numbness
 - C. I have moderate numbness
 - D. I have severe numbness
 - E. I have very severe numbness
10. **Do you have tingling sensations in your hand?**
 - A. No tingling
 - B. Mild tingling
 - C. Moderate tingling
 - D. Severe tingling
 - E. Very severe tingling
11. **How often did hand numbness or tingling wake you up during a typical night?**
 - A. Never
 - B. Once
 - C. Two to three times
 - D. Four or five times
 - E. More than five times

Functional Status Scale: On a typical day during the past 2 weeks, have hand and/or wrist symptoms caused you to have any difficulty doing the activities listed below? Please circle one number that best describes your ability to do the activity.

ACTIVITY	No Difficulty	Mild Difficulty	Moderate Difficulty	Severely Difficulty	Cannot do at all
Writing	A	B	C	D	E
Buttoning of Clothes	A	B	C	D	E
Holding a Book While Reading	A	B	C	D	E
Gripping of a Telephone Handle	A	B	C	D	E
Opening of Jars	A	B	C	D	E
Household Chores	A	B	C	D	E
Carrying of Grocery Bags	A	B	C	D	E
Bathing and Dressing	A	B	C	D	E

Name: _____

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Date: _____