F.I.R.S.T HEALTH

CTS 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, **4**= Very Severe

SYMPTOM SEVERITY SCALE

QUESTIONS- 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 your hand or wrist pain wake you up during a typical night in the past two weeks (times/night)?	0	1	2-3	4-5	4
3	Do you typically have pain in your hand or wrist during daytime?	0	1	2	3	5+
4	How often do you have hand or wrist pain last 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 (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

SCORE:_____/_____

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	Caring of grocery bags	0	1	2	3	4
8	Bathing and Dressing	0	1	2	3	4

SCORE:_____/_____

COMMENTS:

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_____

NAME: _____ **DATE:** _____ **SIGNATURE:**_____

Levine DW Simmons HP, Koris MJ, Hohl GG, Fossel AH, Katz JN. A self-Administered questionnaire for the assessment of severity of symptoms and functional status in carnal tunnel syndrome. J Bone and Joint Surgery, 1993; 75-A; 1585-1592