## *Springfield Orthopaedic & Sports Medicine Institute*
# *Upper Extremity Assessment*

**Patient Name:**_______________________________________________ **Date** _________________________

**Birth Date:** _____________________________ **Occupation:** ________________________________________

**INVOLVED EXTREMITY**

**SHOULDER ELBOW WRIST HAND / RIGHT LEFT BOTH**

**Was there an injury? YES NO Date of Injury** __________________________________

**Were you injured at work? YES NO If not, where?** _________________________________

**Describe what happened in detail:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Primary Care Doctor's Name** ___________________________________________________________________

**Who Referred You To Us?** _____________________________________________________________________

**Please Circle Answers Below**

**Additional information related to your upper extremity problem:**

**Quality: Aching Boring Pins/Needles Sharp Sore Stabbing Stinging Throbbing**
**Other:** ___________________________________________________________________________

**Severity: Mild Moderate Severe**

**Rate the Pain: (No pain) 0----1----2----3----4----5----6----7----8----9----10 (Severe pain)**

**Does this pain affect your sleep? YES NO**

**Do you have: Radiating pain Numbness Tingling**

**Functional Impairment: Mild Mild-Moderate Moderate Severe/Disabling**

**Are you currently in pain? YES NO When did it start? Days_____ Weeks_____ Months_____Years _____**

**Aggravating Factors: Overhead lifting Repetitive lifting Sports Other** ___________________________

**Relieving Factors: Cold Heat Massage Other:** _______________________________________

**Joint Symptoms: Grinding Giving Away Instability Locking Looseness Loss of Motion Popping Swelling**

**Tender to Touch Other** __________________________________________________________

**Previous treatment for this problem? YES NO Of so, what?** ________________________________

_____________________________________________________________________________________________

** Dr. Thompson and Dr. Galluch are investors in Ohio Valley Surgical Hospital. At times they refer patients to Ohio Valley Surgical Hospital in connection with their care and treatment.*