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.*