UPPER EXTREMITY PAIN QUESTIONNAIRE

Complete this section if you experience pain or other symptoms in your fingers, hands, wrists, elbows, 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 = Moderately
7-10 = Severe or greatly

	0	1	2	3	4	5	6	7	8	9	10
1. Sleeping											
2. Getting milk jug											
3. Lifting a heavy box											
4. Reaching overhead											
5. Using a hammer											
6. Picking up small objects											
7. Opening jars											
8. Writing											
9. Driving over 30 minutes											
10. Hobbies											
11. Performing your job											
12. Keyboarding											
13. Carrying bags											
14. Grooming											
15. Cooking											
16. Housecleaning											
17. Dressing											

Comments: _____

_____

_____

NAME: _____ **DATE:** _____ **AGE:**____

Please Indicate the Location of Your Pain

You may use the letters below to indicate the type of sensations you experience

A= Ache
P= Pins & Needles

B=Burning
S= Stabbing

N= Numbness
O= Other