Carpal Tunnel Syndrome Questionnaire

Name: **M/F** **Age** **Date:** **DOB:**

The following questions refer to your symptoms for a typical 24 hour period during the past two weeks (Circle one answer for each question)

Symptom Severity	Never	Mild	Mod	Severe	Very Severe
How severe is the hand or wrist pain that you have at night?	0	1	2	3	4
How often did the hand/wrist pain wake you on a typical night?	0	1	2-3	4-5	5+
Do you typically have pain in your hand during the daytime?	0	1	2	3	4
How often do you have wrist/hand pain during the day?	0	1-2	3-4	5+	Constant
How many minutes does a typical episode last during the day?	0	<10	10-60	>60	Constant
Do you have numbness (loss of sensation) in the hand?	0	1	2	3	4
Do you have weakness in the hand/wrist?	0	1	2	3	4
Do you have tingling in the hand/wrist?	0	1	2	3	4
How severe is the numbness or tingling at night?	0	1	2	3	4
How often did the hand/wrist numbness wake you on a typical night?	0	1	2	3	4
Do you have trouble grasping small objects like keys or pens?	0	1	2	3	4

Functional Status – Rate the following according to difficulty or symptoms

Writing	0	1	2	3	4
Buttoning Clothes	0	1	2	3	4
Holding a Book While Reading	0	1	2	3	4
Holding a Telephone	0	1	2	3	4
Opening of Jars	0	1	2	3	4
Household Chores	0	1	2	3	4
Carrying Grocery Bags	0	1	2	3	4
Bathing and Dressing	0	1	2	3	4

Comments

Modified from Levine DW, Simmons, HP, Koris MJ, et al. A self administered questionnaire for the assessment of severity of symptoms and functional status in carpal tunnel syndrome *J Bone Joint Surgery* 1993; 74A: 1585-1592