Name _____ Date_____

Carpal Tunnel Syndrome Questionnaire

Check in the appropriate box: Do you have problems with your ☐ Right Wrist ☐ Left Wrist ☐ Both Wrists

The following questions refer to your symptoms for a typical twenty-four hour period during the past two weeks. Check one answer to each question.

Symptom Severity Scale	None	Mild	Moderate	Severe	Very Severe
1. How severe is the hand or wrist pain that you have at night?					
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks (times/day)?	0x	1x	2-3x	4-5x	5+x
3. Do you typically have pain in your hand or wrist during the day time?					
4. How often do you have hand or wrist pain during the daytime (times/day)?	0x	1-2x	3-5x	5+x	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?					
7. Do you have weakness in your hand or wrist?					
8. Do you have tingling sensations in your hand?					
9. How severe is numbness (loss of sensation) or tingling at night?					
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?	0x	1x	2-3x	4-5x	5+x
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?					

Functional Status Scale	None	Mild	Moderate	Severe	Very Severe
1. Writing					
2. Buttoning of clothes					
3. Holding a book while reading					
4. Gripping of a telephone handle					
5. Opening of jars					
6. Household chores					
7. Carrying of grocery bags					
8. Bathing and dressing					
	1	2	3	4	5

Comments: _____

_____

Patient Signature:_____

Symptom Severity Score: Total Points: _____ Standardized on a 0 to 10 scale: _____

Functional Status Score: Total Points: _____ Functional % Disability:_____

Levine DW, Simmons HP, Koris MJ, et al. A self-administered questionnaire for the assessment severity of symptoms and functional status in carpal tunnel syndrome. J Bone Joint Surg 1993;75A:1585-1592.