

**GARDINER FAMILY CHIROPRACTIC
CARPAL TUNNEL SYNDROME QUESTIONNAIRE**

Name _____ Date _____

The purpose of this questionnaire is to measure your perceived disability from your carpal tunnel syndrome. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

INSTRUCTIONS: In each section, mark with an "X" only *one* box which most closely applies to your *carpal tunnel syndrome*. Please answer every section.

How severe is the hand or wrist pain that you have at night?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

Do you have numbness (loss of sensation) in your hand?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

How often did your hand or wrist pain wake you up during a typical night in the past 2 weeks (times/day)?

<input type="checkbox"/>	0	Never
<input type="checkbox"/>	1	1
<input type="checkbox"/>	2	2 to 3
<input type="checkbox"/>	3	4 to 5
<input type="checkbox"/>	4	5 or more

Do you have weakness in your hand or wrist?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

Do you typically have pain in your hand or wrist during the daytime?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

Do you have tingling sensations in your hand?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

How often do you have hand or wrist pain during the daytime (times/day)?

<input type="checkbox"/>	0	0x
<input type="checkbox"/>	1	1-2x
<input type="checkbox"/>	2	3-5x
<input type="checkbox"/>	3	5+x
<input type="checkbox"/>	4	constant

How severe is numbness (loss of sensation) or tingling at night?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe

How long, on average, does an episode of pain last during the daytime (minutes)?

<input type="checkbox"/>	0	0
<input type="checkbox"/>	1	<10
<input type="checkbox"/>	2	10-60
<input type="checkbox"/>	3	>60
<input type="checkbox"/>	4	Constant

How often did hand numbness or tingling wake you up during a typical night during the past two weeks?

<input type="checkbox"/>	0	0x
<input type="checkbox"/>	1	1x
<input type="checkbox"/>	2	2-3x
<input type="checkbox"/>	3	4-5x
<input type="checkbox"/>	4	5+x

Do you have difficulty with the grasping of small objects such as keys or pens?

<input type="checkbox"/>	0	None or never
<input type="checkbox"/>	1	Mild
<input type="checkbox"/>	2	Moderate
<input type="checkbox"/>	3	Severe
<input type="checkbox"/>	4	Very Severe