GARDINER FAMILY CHIROPRACTIC
WRIST PAIN QUESTIONNAIRE

Name ____ Date ____________________________________

The purpose of this questionnaire is to measure your perceived disability from your wrist. 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 a circle only *one* number which most closely applies to your *wrist. Please answer every section*.

Regarding your AVERAGE wrist symptoms OVER THE PAST WEEK when your wrist is at rest.

No Pain 0 1 2 3 4 5 6 7 8 9 Worst Pain Ever

Regarding your AVERAGE wrist symptoms OVER THE PAST WEEK when doing a task with a repeated wrist movement.

No Pain 0 1 2 3 4 5 6 7 8 9 Worst Pain Ever

Regarding your AVERAGE wrist symptoms OVER THE PAST WEEK when lifting a heavy object.

No Pain 0 1 2 3 4 5 6 7 8 9 Worst Pain Ever

Regarding your AVERAGE wrist symptoms OVER THE PAST WEEK when it is at its worst.

No Pain 0 1 2 3 4 5 6 7 8 9 Worst Pain Ever

Regarding your AVERAGE wrist symptoms OVER THE PAST WEEK how often do you have pain?

Never 0 1 2 3 4 5 6 7 8 9 Alwatys

Over the past week, describe your difficulty with turning a doorknob using your affected hand.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with cutting meat with a knife in your affected hand.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with fastening buttons on your shirt.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with using your affected hand to push up from a chair.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with carry a 10 lbs. object in your affected hand.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with using bathroom tissue with your affected hand.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with personal care activities (dressing, washing).

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with household work (cleaning, maintenance).

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with work (your job or usual everyday work).

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable

Over the past week, describe your difficulty with recreational activities.

No difficulty 0 1 2 3 4 5 6 7 8 9 Unable