



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Elbow/Wrist/Hand Intake Survey:**

**1. In general, would you say your health is:**

Excellent                  Very Good                  Good                  Fair                  Poor

**2. How much difficulty do you have turning a key and/or opening doors?**

Unable to perform                  A lot                  Some                  A little                  None

**3. How much difficulty do you have washing your back?**

Unable to perform                  A lot                  Some                  A little                  None

**4. How much difficulty do you have carrying items that weigh > 10 pounds?**

Unable to perform                  A lot                  Some                  A little                  None

**5. How much difficulty do you have gripping objects?**

Unable to perform                  A lot                  Some                  A little                  None

**6. Please indicate your pain range within the last week giving a score for the lowest and highest on the scale below.**

No pain 0      1      2      3      4      5      6      7      8      9      10 Worst pain ever