

# Upper Extremity Evaluation

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit: Shoulder Elbow Wrist Hand Other: \_\_\_\_\_

Side: Left Right Both Hand Dominance: Left Right Date of injury/Symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this problem related to an injury? Yes No Motor vehicle accident?  work related injury?  sports related injury?

Describe how the injury occurred: \_\_\_\_\_

Have you had surgery on this body part? \_\_\_\_\_ If yes, Procedure and Date: \_\_\_\_\_

Onset: Sudden Gradual Duration: How long have you had this problem:# \_\_\_\_ Hours Days Weeks Months Years

Pattern:  Constant  Intermittent  Persistent Course: Improving Worsening Recurrent Without Change

Radiation of Pain: None Neck Elbow Hand Fingers

<b>Location:</b>	<b>Severity of Pain:</b>	<b>Characterized As:</b>	<b>Associated Features</b>
<input type="checkbox"/> Front <input type="checkbox"/> Back	<input type="checkbox"/> None	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull	<input type="checkbox"/> Swelling <input type="checkbox"/> Loss of Motion
<input type="checkbox"/> Top	<input type="checkbox"/> Mild	<input type="checkbox"/> Aching <input type="checkbox"/> Throbbing	<input type="checkbox"/> Stiffness <input type="checkbox"/> Painful Motion
<input type="checkbox"/> Outside	<input type="checkbox"/> Mild to Moderate	<input type="checkbox"/> Cramping <input type="checkbox"/> Stabbing	<input type="checkbox"/> Popping <input type="checkbox"/> Dislocation
<input type="checkbox"/> Underarm	<input type="checkbox"/> Moderate	<input type="checkbox"/> Night Pain <input type="checkbox"/> Burning	<input type="checkbox"/> Grinding <input type="checkbox"/> Catching
<input type="checkbox"/> Shoulder Blade	<input type="checkbox"/> Moderate to Severe	<input type="checkbox"/> Numbness <input type="checkbox"/> Shooting	<input type="checkbox"/> Instability <input type="checkbox"/> Redness
<input type="checkbox"/> Entire Joint	<input type="checkbox"/> Severe	<input type="checkbox"/> Tightness <input type="checkbox"/> Like Band Around Arm	<input type="checkbox"/> Weakness <input type="checkbox"/> Warmth

<b>Aggravated by:</b>	<b>Relieved by:</b>	<b>Physical Therapy For this injury?</b>	<b>Use of Assisted devices:</b>
<input type="checkbox"/> Nothing	<input type="checkbox"/> Nothing	<input type="checkbox"/> Yes	<input type="checkbox"/> None
<input type="checkbox"/> Pushing	<input type="checkbox"/> Rest	<input type="checkbox"/> No	<input type="checkbox"/> Sling
<input type="checkbox"/> Pulling	<input type="checkbox"/> Rest <input type="checkbox"/> Side Lying	When? _____	<input type="checkbox"/> Immobilizer
<input type="checkbox"/> Reaching	<input type="checkbox"/> Any Movement	Where? _____	
<input type="checkbox"/> Lifting	<input type="checkbox"/> Physical Activities		
<input type="checkbox"/> Throwing	<input type="checkbox"/> Sports Activities		
	<input type="checkbox"/> Work Activities		
	<input type="checkbox"/> Overhead Activities		
	<input type="checkbox"/> Massage		
	<input type="checkbox"/> Modified Activity		
	<input type="checkbox"/> Physical Therapy		
	<input type="checkbox"/> Ice		
	<input type="checkbox"/> Heat		
	<input type="checkbox"/> Exercise		
	<input type="checkbox"/> Medication		
	<input type="checkbox"/> Bracing		
	<input type="checkbox"/> Cortisone Injections		

Previous Diagnostic Tests: X-ray MRI CT Scan Arthrogram Bonescan EMG/NCS

\*Where was it taken?: \_\_\_\_\_

## Review of Symptoms

Please check all that apply

<b>General:</b> <input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue  <b>Skin:</b> <input type="checkbox"/> Bruising <input type="checkbox"/> Rash  <b>Respiratory:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	<b>Cardiovascular:</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema  <b>Gastrointestinal:</b> <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea  <b>Psychiatric:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia	<b>Musculoskeletal:</b> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Leg Cramps  <b>Hematology:</b> <input type="checkbox"/> Calf Pain <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	<b>Neurological:</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches  <b>Geniurinary:</b> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Difficulty Urinating
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Patient Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_