



UPPER EXTREMITY QUESTIONNAIRE

Name: Chart # : Date:

What upper extremity part are we seeing you for today? Right Left Both

Date of Injury: If no injury, when did your symptoms begin?

Is this injury: job/work related motor vehicle accident other accident

IF AN INJURY, PLEASE COMPLETE THE FOLLOWING

Have you seen another Physician for this injury? When? Physician's name:

Is this appointment for a second opinion? Name of Physician you saw for 1st opinion:

List all medications you have taken related to this injury:

Have you had any therapy for this injury including home or physical?

Are you currently out of work or on limited duty due to this injury/problem?

Do we need to address work duty status or limitations today?

PLEASE WRITE A DESCRIPTION OF HOW YOUR INJURY HAPPENED

- AND/OR -

DESCRIBE YOUR SYMPTOMS AND YOUR REASON TO BE SEEN

*Patient or Guardian signature: Date:

**By typing your name in this area you are stating the above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.*