Mean

Carpal Tunnel Worksheet

Name: _____Age: _____ How were you referred? _____

Occupation: _____

Treatments you would like to discuss: _____

Problem Hand:

- ☐ Right
- ☐ Left
- ☐ Both

How long has this bothered you?

_____

Dominant hand:

- ☐ Right
- ☐ Left

Pain is:

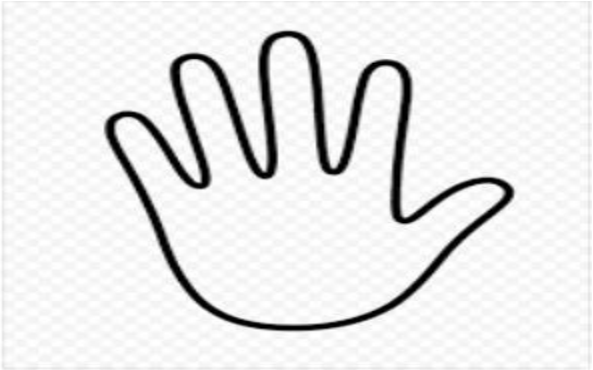
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Pain is getting

- ☐ Worse
- ☐ Better
- ☐ Unchanged recently

When does it bother you? Driving? Reading a book? Sleep? holding a phone?_____

If you had to choose three fingers that bother you the most which ones would you choose? Choose below



Does this interrupt your sleep? Y/N

Have you had an EMG? Y/N When?_____

Have you tried night splint/brace? Y/N Did it help? Y/N

Have over the counter medications helped? Y/N

Does rest help? Y/N

Any history of surgery on your hand? _____

Have you ever had carpal tunnel release/surgery?_____

Anything else you would like us to know?_____

_____

Doctor to fill out

Prior scars **Atrophy** **CCT** **Tinels** **Sensation**

PLAN:

Carpal Tunnel Release

EMG ordered