

PATIENT RATED ULNAR NERVE EVALUATION

Name: _____

Date: _____

*The questions below will help us to understand the amount of pain or difficulty you experience because of your hand/arm. Please describe your **average** experience **over the past week**.*

RATE YOUR PAIN :	<i>0=No Pain</i>	<i>10 = Worst Possible</i>
When it is at its worst	0 1 2 3 4 5 6 7 8 9 10	
At rest	0 1 2 3 4 5 6 7 8 9 10	
In the morning	0 1 2 3 4 5 6 7 8 9 10	
After work/activity	0 1 2 3 4 5 6 7 8 9 10	
At night (when sleeping)	0 1 2 3 4 5 6 7 8 9 10	
How <u>often</u> do you have pain?	Never 0 1 2 3 4 5 6 7 8 9 10 Always	
RATE YOUR OTHER SYMPTOMS :	<i>0= None</i>	<i>10= Worst Possible</i>
Numbness in my little(5th) finger	0 1 2 3 4 5 6 7 8 9 10	
"Pins and needles" in my little finger	0 1 2 3 4 5 6 7 8 9 10	
Unable to control the position/movement of my little finger	0 1 2 3 4 5 6 7 8 9 10	
Weakness in my hand (pinch/grip)	0 1 2 3 4 5 6 7 8 9 10	



RATE YOUR DIFFICULTY Performing These Activities	<i>0= No difficulty</i>	<i>10= Completely unable</i>
Eat (use fork, knife, or chopsticks)	0 1 2 3 4 5 6 7 8 9 10	
Lift a heavy object	0 1 2 3 4 5 6 7 8 9 10	
Hold an object (a tool, book, phone or electronic device) for 1 hour	0 1 2 3 4 5 6 7 8 9 10	
Repeated reaching	0 1 2 3 4 5 6 7 8 9 10	
Tasks with repetitive finger use –like typing, playing musical instruments or handling small objects	0 1 2 3 4 5 6 7 8 9 10	
Turn a key/doorknob/handle	0 1 2 3 4 5 6 7 8 9 10	
Usual Activities - Rate your difficulty doing the <i>usual activities that you did before your hand/arm problem started</i> . 0 means you have no difficulty with ANY of your usual activities; and 10 means you are completely unable to ANY of your usual activities.		
	<i>0= No difficulty</i>	<i>10= Completely unable</i>
Personal care activities (like washing, dressing)	0 1 2 3 4 5 6 7 8 9 10	
Household (cleaning, maintenance)	0 1 2 3 4 5 6 7 8 9 10	
Work (your job or everyday work)	0 1 2 3 4 5 6 7 8 9 10	
Recreational activities	0 1 2 3 4 5 6 7 8 9 10	