**Medico-Legal Evaluations, P.A.**
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# Upper Extremity (Arm) Questionnaire

Fill out only the form(s) for the body area(s) that were injured. Type into this form on a computer or phone, save it and email it to **info@mlenj.com** before your appointment, or print it and bring it. Please also bring any X-ray, MRI or CT films or discs.

**Full name** | **Date of birth** | **Today's date**

## Your injury

**When did the injury happen?** **Are you right- or left-handed?** ☐ Right ☐ Left

**Which part was injured? (check all that apply; if both sides, check both rows)**

| | Shoulder | Upper arm | Elbow | Forearm | Wrist | Hand | Finger(s) |
|---|---|---|---|---|---|---|---|
| **Left** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Right** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**How did the injury happen?**

## Before and after this injury

**Before this injury, did you have any of these? (check all that apply)**

☐ An arm or hand injury ☐ Arm or hand pain or problems ☐ Arm or hand treatment ☐ None of these

**If you checked any, when and what happened (for example, another accident)?**

**Any other accidents or injuries since this injury?** ☐ Yes ☐ No If yes, what happened?

## Treatment and work

**Which treatments have you had for this injury? (check all that apply)**

☐ Surgery ☐ Injections ☐ Physical therapy ☐ Cast, splint or brace Other:

**Work status: (check one)**

☐ Full duty ☐ Light or restricted duty ☐ Not working because of this injury ☐ Retired ☐ Not working, other reason

**Your job (or last job):**

## Pain

**Do you have pain right now?** ☐ Yes ☐ No

**Pain right now**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

**Pain at its worst in the last week**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

**Where is the pain now? (check all that apply)**

| | Shoulder | Upper arm | Elbow | Forearm | Wrist | Hand | Finger(s) |
|---|---|---|---|---|---|---|---|
| **Left** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Right** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**What is the pain like? (check all that apply)**

☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Stinging

Other: _____

**How often do you have pain?** ☐ Sometimes ☐ Most of the time ☐ All the time

**Do you have numbness, tingling or other unusual feelings in your arms or hands?** ☐ Yes ☐ No

**If yes, which side?** ☐ Left ☐ Right ☐ Both Describe: _____

**Pain medications you take:** _____

## Activities

Which of these activities are harder for you **because of the injury or injuries described on this form?** For each activity, **check only one box**. Leave the row blank if the injury does not affect that activity.

| Activity | I can't do it anymore | I can do it, but less than before | I can do it normally, but feel pain |
|---|---|---|---|
| **Hand and arm use** | | | |
| Typing or using a computer | ◯ | ◯ | ◯ |
| Writing | ◯ | ◯ | ◯ |
| Using tools | ◯ | ◯ | ◯ |
| Opening jars | ◯ | ◯ | ◯ |
| Buttons and zippers | ◯ | ◯ | ◯ |
| **Lifting, carrying and reaching** | | | |
| Lifting | ◯ | ◯ | ◯ |
| Carrying objects | ◯ | ◯ | ◯ |
| Picking up children | ◯ | ◯ | ◯ |
| Reaching overhead | ◯ | ◯ | ◯ |
| **Household tasks** | | | |
| Doing laundry | ◯ | ◯ | ◯ |
| Cooking | ◯ | ◯ | ◯ |
| Vacuuming or sweeping | ◯ | ◯ | ◯ |
| Doing repairs | ◯ | ◯ | ◯ |
| **Exercise and recreation** | | | |
| Playing sports | ◯ | ◯ | ◯ |
| Working out | ◯ | ◯ | ◯ |
| Riding a bicycle | ◯ | ◯ | ◯ |
| **Daily activities** | | | |
| Bathing or showering | ◯ | ◯ | ◯ |
| Driving | ◯ | ◯ | ◯ |
| Sleeping | ◯ | ◯ | ◯ |

**Any other activities that are harder because of this injury:** _____