

## CARPAL TUNNEL SYNDROME QUESTIONNAIRE ( CTSQ)

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

The following questions refer to your symptoms for a typical twenty-four hour period during the past two weeks.  
Circle one answer to each question.

**SEVERITY & FUNCTIONAL SCALE:**    1 = None or Never    2 = Mild    3 = Moderate    4 = Severe    5 = Very severe

### SYMPTOM SEVERITY SCALE

1. How severe is the hand or wrist pain that you have at night?	1	2	3	4	5
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks (times/day)?	0x	1x	2-3x	4-5x	5+x
3. Do you typically have pain in your hand or wrist during the daytime?	1	2	3	4	5
4. How often do you have hand or wrist pain during the daytime (times/day)?	0x	1-2x	3-5x	5+x	constant
5. How long, on average, does an episode of pain last during the daytime (minutes)?	0	<10	10-60	>60	constant
6. Do you have numbness (loss of sensation) in your hand?	1	2	3	4	5
7. Do you have weakness in your hand or wrist?	1	2	3	4	5
8. Do you have tingling sensations in your hand?	1	2	3	4	5
9. How severe is numbness (loss of sensation) or tingling <i>at</i> night?	1	2	3	4	5
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?	0x	1x	2-3x	4-5x	5+x
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?	1	2	3	4	5

### FUNCTIONAL STATUS SCALE

1. Writing	1	2	3	4	5
2. Buttoning of clothes	1	2	3	4	5
3. Holding a book while reading	1	2	3	4	5
4. Gripping of a telephone handle	1	2	3	4	5
5. Opening of jars	1	2	3	4	5
6. Household chores	1	2	3	4	5
7. Carrying of grocery bags	1	2	3	4	5
8. Bathing and dressing	1	2	3	4	5

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_

**EXAMINER:** \_\_\_\_\_

## PATIENT RATED WRIST EVALUATION

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

The questions below will help us understand how much difficulty you have had with your wrist in the past week. You will be describing your average wrist symptoms over the past week on a scale of 0-10. Please provide an answer for ALL questions. If you did not perform an activity, please ESTIMATE the pain or difficulty you would expect. If you have never performed the activity, you may leave it blank.

**I. PAIN**

Rate the average amount of pain in your wrist over the past week by circling the number that best describes your pain on a scale from 0-10. A zero (0) means that you did not have any pain and a ten (10) means that you had the worst pain you have every experienced or that you could not do the activity because of pain.

Sample scale: 0   1   2   3   4   5   6   7   8   9   10  
 No Pain Worst Ever Pain

**Rate your pain:**

- |    |  |   |   |   |   |   |   |   |   |   |   |        |
|----|--|---|---|---|---|---|---|---|---|---|---|--------|
| 1. | At rest  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10     |
| 2. | When doing a task with a repeated wrist movement | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10     |
| 3. | When lifting a heavy object                      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10     |
| 4. | When it is at its worst                          | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10     |
| 5. | How often do you have pain                       | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10     |
|    | Never  |   |   |   |   |   |   |   |   |   |   | Always |

**II. FUNCTION**

**A. Specific Activities**

Rate the amount of difficulty you experienced performing each of the items listed below over the past week, by circling the number that describes your difficulty on a scale of 0-10. A zero (0) means you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do it at all.

- |               |   |   |   |   |   |   |   |   |   |   |    |    |
|---------------|---|---|---|---|---|---|---|---|---|---|----|----|
| Sample scale: | 0   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |    |
|               | No Difficulty <span style="float: right;">Unable To Do</span> |   |   |   |   |   |   |   |   |   |    |    |
| 1.            | Turn a door knob using my affected hand                       | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |
| 2.            | Cut meat using a knife in my affected hand                    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |
| 3.            | Fasten buttons on my shirt                                    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |
| 4.            | Use my affected hand to push up from a chair                  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |
| 5.            | Carry a 10 lb object in my affect hand                        | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |
| 6.            | Use bathroom tissue with my affected hand                     | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10 |

**B. Usual Activities**

Rate the amount of difficulty you experienced performing your usual activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. By "usual activities", we mean the activities you performed before you started having a problem with your wrist. A zero (0) means that you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do any of your usual activities.

- |    |  |   |   |   |   |   |   |   |   |   |   |    |
|----|--|---|---|---|---|---|---|---|---|---|---|----|
| 1. | Personal care activities (dressing, washing) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | Household work (cleaning, maintenance)       | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | Work (your job or usual everyday work)       | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. | Recreational activities                      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Examiner:** \_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

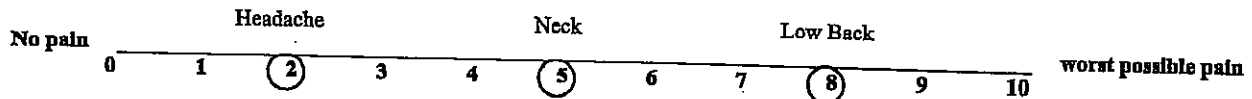
Date \_\_\_\_\_

**Please read carefully:**

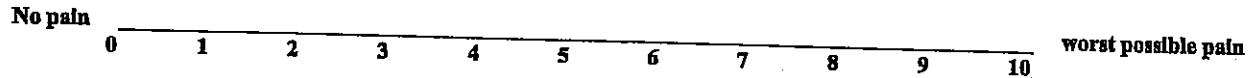
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

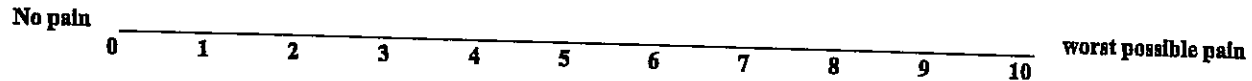
**Example:**



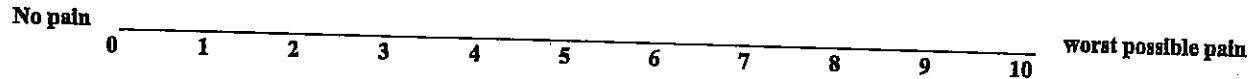
**1 – What is your pain RIGHT NOW?**



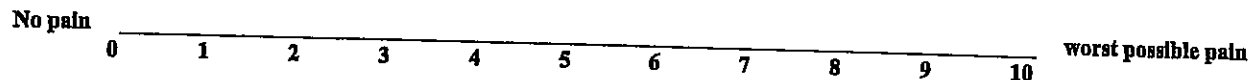
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**



**OTHER COMMENTS:**

Examiner \_\_\_\_\_

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