

# HAND/FINGER EVALUATION

Last Name:	First:	Date:
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**THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY**

1. What do you think is wrong?  
\_\_\_\_\_
2. Describe your symptoms:  
\_\_\_\_\_  
\_\_\_\_\_
3. What makes it better?  
\_\_\_\_\_
4. What makes it worse?  
\_\_\_\_\_  
\_\_\_\_\_
5. Do you have areas of weakness? Yes or No (Circle one)
6. Weakness where?  
\_\_\_\_\_  
\_\_\_\_\_
7. Any surgery/arthroscopy on the scan area? Yes or No (Circle one)
8. Surgery/Arthroscopy when?  
\_\_\_\_\_  
\_\_\_\_\_
9. What was done?  
\_\_\_\_\_  
\_\_\_\_\_
10. Do you have arthritis in any of your joints? Yes or No (Circle one)
11. List Joints:  
\_\_\_\_\_  
\_\_\_\_\_
12. Are you currently taking any medications? Yes or No (Circle one)
13. List medications:  
\_\_\_\_\_  
\_\_\_\_\_
14. Do you have any other medical conditions? Yes or No (Circle one)
15. List conditions:  
\_\_\_\_\_  
\_\_\_\_\_
16. List athletic activities that may have contributed to your condition:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_