

WRIST EVALUATION

Last Name:	First:	Date:
------------	--------	-------

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:

