



NEW BERLIN
CHIROPRACTIC &
THERAPY CENTER

CTS QUESTIONNAIRE

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 SCALE: 0 = None or Never; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very severe

SYMPTOM SEVERITY SCALE

QUESTION	SEVERITY SCORE 0= NONE; 4=SEVERE	0	1	2	3	4
1. How severe is the hand or wrist pain that you have at night?		0	1	2	3	4
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks (times/night)?		0	1	2-3	4-5	5+
3. Do you typically have pain in your hand or wrist during the daytime?		0	1	2	3	4
4. How often do you have hand or wrist pain during the daytime (times/day)?		0	1-2	3-5	5+	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?		0	1	2	3	4
7. Do you have weakness in your hand or wrist?		0	1	2	3	4
8. Do you have tingling sensations in your hand?		0	1	2	3	4
9. How severe is numbness (loss of sensation) or tingling at night?		0	1	2	3	4
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?		0	1	2-3	4-5	5+
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?		0	1	2	3	4

FUNCTIONAL STATUS SCALE

QUESTION	SEVERITY SCORE 0= NONE; 4=SEVERE	0	1	2	3	4
1. Writing		0	1	2	3	4
2. Buttoning of clothes		0	1	2	3	4
3. Holding a book while reading		0	1	2	3	4
4. Gripping of a telephone handle		0	1	2	3	4
5. Opening of jars		0	1	2	3	4
6. Household chores		0	1	2	3	4
7. Caring of grocery bags		0	1	2	3	4
8. Bathing and Dressing		0	1	2	3	4

COMMENTS: _____

NAME _____ M/F _____ AGE _____ DATE _____ DOI _____

Symptom _____ / 44 _____ %
Functional _____ / 32 _____ %