

Name: _____

SYMPTOM SEVERITY SCALE (CTS)



The following questions refer to your symptoms for a typical 24hr. period during the last 2 weeks (circle one answer to each question).

<p>1. How severe is the hand or wrist pain that you have at night?</p> <ul style="list-style-type: none"> <input type="radio"/> I do not have hand or wrist pain <input type="radio"/> Mild pain <input type="radio"/> Moderate pain <input type="radio"/> Severe pain <input type="radio"/> Very severe pain 	<p>7. Do you have weakness in your hand or wrist?</p> <ul style="list-style-type: none"> <input type="radio"/> No weakness <input type="radio"/> Mild weakness <input type="radio"/> Moderate weakness <input type="radio"/> Severe weakness <input type="radio"/> Very severe weakness
<p>2. How often did hand or wrist pain wake you up during a typical night I the past two weeks?</p> <ul style="list-style-type: none"> <input type="radio"/> Never <input type="radio"/> Once <input type="radio"/> Two to three times <input type="radio"/> Four or five times <input type="radio"/> More than five times 	<p>8. Do you have tingling sensations in your hand?</p> <ul style="list-style-type: none"> <input type="radio"/> No tingling <input type="radio"/> Mild tingling <input type="radio"/> Moderate tingling <input type="radio"/> Severe tingling <input type="radio"/> Very severe tingling
<p>3. Do you typically have pain in your hand or wrist during the day time?</p> <ul style="list-style-type: none"> <input type="radio"/> I never have pain during the day <input type="radio"/> I have mild pain during the day <input type="radio"/> I have moderate pain during the day <input type="radio"/> I have severe pain during the day <input type="radio"/> I have very severe pain during the day 	<p>9. How severe is numbness (loss of sensation) or tingling at night?</p> <ul style="list-style-type: none"> <input type="radio"/> I have no numbness or tingling at night <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Very severe
<p>4. How often do you have hand or wrist pain during the daytime?</p> <ul style="list-style-type: none"> <input type="radio"/> Never <input type="radio"/> Onnce or twice a day <input type="radio"/> Three to five times a day <input type="radio"/> More than five times a day <input type="radio"/> The pain is constant 	<p>10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?</p> <ul style="list-style-type: none"> <input type="radio"/> Never <input type="radio"/> Once <input type="radio"/> Two or three times <input type="radio"/> Four or five times <input type="radio"/> More than five times
<p>5. How long, on average, does an episode of pain last during the daytime?</p> <ul style="list-style-type: none"> <input type="radio"/> I never get pain during the day <input type="radio"/> Less than 10 minutes <input type="radio"/> 10 to 60 minutes <input type="radio"/> Greater than 60 minutes <input type="radio"/> The pain is constant throughout the day 	<p>11. Do you have difficulty with the grasping and use of small objects such as keys or pens?</p> <ul style="list-style-type: none"> <input type="radio"/> No difficulty <input type="radio"/> Mild difficulty <input type="radio"/> Moderate difficulty <input type="radio"/> Severe difficulty <input type="radio"/> Very severe difficulty
<p>6. Do you have numbness (loss of sensation) in your hand?</p> <ul style="list-style-type: none"> <input type="radio"/> No <input type="radio"/> I have mild numbness <input type="radio"/> I have moderate numbness <input type="radio"/> I have severe numbness <input type="radio"/> I have very severe numbness 	

Name: _____ **FUNCTIONAL STATUS SCALE (CTS)**



On a typical day during the past two weeks have hand and wrist symptoms caused you to have any difficulty doing the activities listed below? Please circle one number that best describes your ability to do the activity.

ACTIVITY	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	CANNOT DO AT ALL DUE TO HAND OR WRIST SYMPTOMS
Writing	1	2	3	4	5
Buttoning of clothes	1	2	3	4	5
Holding a book while reading	1	2	3	4	5
Gripping of a telephone handle	1	2	3	4	5
Opening of jars	1	2	3	4	5
Household Chores	1	2	3	4	5
Carrying of grocery bags	1	2	3	4	5
Bathing and dressing	1	2	3	4	5

MCID- Not established; SRM: SSS=1.75 - 2.02; FSS- .96 - 1.26

From: Levine: J Bone Joint Surg Am, Volume 75-A(11).November , 1993.1585-1592. A self-administered questionnaire for the assessment of severity of symptoms and functional status in carpal tunnel syndrome.