Elbow Pain Questionnaire

Name_____

Which elbow is bothering you? Left Right Both

Are your left handed or right handed? Left Right

Did your elbow pain start with a specific injury? Yes No
If yes: Date of injury: _____
Mechanism of injury _____
Is the injury work related? Yes No

Did your elbow pain start with a particular activity? Yes No
If yes, what activity started the pain? _____

If there was no injury, when did the pain start? _____

What part of your elbow hurts? Front Inside Outside Back

What are your primary sports and/or activities? _____

How would you describe your pain? (constant, intermittent, mild, severe, etc.)
_____

Does your pain radiate up or down your arm? Yes No

Do any of the following increase your elbow pain?

Lifting or carrying:	Yes	Minimally	No
Grasping:	Yes	Minimally	No
Throwing motion:	Yes	Minimally	No
Motion of the elbow:	Yes	Minimally	No
Repetitive motion:	Yes	Minimally	No
Work activities:	Yes	Minimally	No
Sports:	Yes	Minimally	No

Is there anything else that increases your pain? _____
_____

Do any of the following decrease your pain?

Rest:	Yes	Minimally	No
Ice:	Yes	Minimally	No
Heat:	Yes	Minimally	No
Over the counter medicines (Tylenol/Advil)	Yes	Minimally	No
Prescription pain medicines:	Yes	Minimally	No

Is there anything else that decreases your pain? _____
_____
_____

Do you have any of the following symptoms?

Clicking or catching in your elbow:	Yes	Minimally	No
Weakness of the elbow:	Yes	Minimally	No
Stiffness:	Yes	Minimally	No
Decreased grip strength:	Yes	Minimally	No
Neck pain:	Yes	Minimally	No
Numbness or tingling in your arm:	Yes	Minimally	No
Pain at night:	Yes	Minimally	No

Are there any other symptoms regarding your elbow? _____
_____
_____

Have you had any prior surgery to your elbow(s)? Yes No
If yes, what type of surgery did you have and when did you have the surgery?
_____
_____

Have you had any prior treatment for your elbow pain such as:

Cortisone injections:	Yes	No
Physical therapy:	Yes	No

In general do you think your elbow pain is:

Getting better?	Yes	No
Getting worse?	Yes	No

Have you had any x-rays taken of your elbow(s): Yes No
If yes: Date of x-rays: _____
X-ray facility: _____

Have you had an MRI of your elbow(s): Yes No
If yes: Date of MRI: _____
MRI facility: _____

Is there anything else we need to know about your elbow pain?

_____
_____