

<b>WRIST</b>	
Location	<input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist <input type="checkbox"/> Both Wrists
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50%  <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain / Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling   / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Swelling <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity  <input type="checkbox"/> Weakness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm  <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand  <input type="checkbox"/> Right Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Left Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At its worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night  After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting  <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Driving <input type="checkbox"/> Extension <input type="checkbox"/> External Rotation <input type="checkbox"/> Flexion  <input type="checkbox"/> Grasping <input type="checkbox"/> Housework <input type="checkbox"/> Internal rotation <input type="checkbox"/> Lifting <input type="checkbox"/> Writing