CARPAL TUNNEL SYNDROME QUESTIONNAIRE (CTSQ)

Patient Name _____ Date_____

Please read carefully:
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 & FUNCTIONAL SCALE: 1 = None or Never 2 = Mild 3 = Moderate 4 = Severe 5 = Very severe

SYMPTOM SEVERITY SCALE

1. How severe is the hand or wrist pain that you have at night?	1	2	3	4	5
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks (times/day)?	0x	1x	2-3x	4-5x	5+x
3. Do you typically have pain in your hand or wrist during the daytime?	1	2	3	4	5
4. How often do you have hand or wrist pain during the daytime (times/day)?	0x	1-2x	3-5x	5+x	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?	1	2	3	4	5
7. Do you have weakness in your hand or wrist?	1	2	3	4	5
8. Do you have tingling sensations in your hand?	1	2	3	4	5
9. How severe is numbness (loss of sensation) or tingling ***at*** night?	1	2	3	4	5
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?	0x	1x	2-3x	4-5x	5+x
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?	1	2	3	4	5

FUNCTIONAL STATUS SCALE

1. Writing	1	2	3	4	5
2. Buttoning of clothes	1	2	3	4	5
3. Holding a book while reading	1	2	3	4	5
4. Gripping of a telephone handle	1	2	3	4	5
5. Opening of jars	1	2	3	4	5
6. Household chores	1	2	3	4	5
7. Carrying of grocery bags	1	2	3	4	5
8. Bathing and dressing	1	2	3	4	5

COMMENTS: _____

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EXAMINER: _____

With permission from: Levine DW, Simmons HP, Koris MJ, et al. A self-administered questionnaire for the assessment severity of symptoms and functional status in carpal tunnel syndrome. *J Bone Joint Surg* 1993;75A:1585-1592.