

## Appendix B:

### Health Outcomes Data Collection Instruments

B.1	Questionnaire .....
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B.7	Pain Scale.....

## **Upper Limb Musculoskeletal Disorders: Baseline Questionnaire**

### Directions:

Please answer each question by pointing the arrow with the mouse and clicking with you index finger to either mark “yes” or “no” or to fill in a blank. If you need help or have any questions please ask one of our research assistants. We’re happy to help!

Code # \_\_\_\_\_  
Date: \_\_\_\_\_

## Upper Limb Musculoskeletal disorders: Baseline Questionnaire

1. Your Company's name: \_\_\_\_\_
2. Job Title / Department: \_\_\_\_\_
3. Age: \_\_\_\_\_.\_\_ (in tenths of a year)
4. Gender:    \_\_\_Male           \_\_\_Female
5. Are you:  
    \_\_\_ Right-handed  
    \_\_\_ Left-handed  
    \_\_\_ Use both hands equally
6. Are you planning on leaving or retiring (from this company) in the next 3 years? \_\_\_\_\_ Yes  
    \_\_\_\_\_ No *If yes, please ask the research assistant before going on.*
7. How long have you worked in your current job? \_\_\_\_\_years    \_\_\_\_\_months

8. Do you get any of the following types of exercise (outside of work) on a regular basis?

Type of Exercise	Yes	No	Number of months per year	Average number of times per week	Average number of minutes each time
Aerobics, Jazzercise			Months	Per week	Minutes
Running, Jogging			Months	Per week	Minutes
Walking			Months	Per week	Minutes
Bicycling			Months	Per week	Minutes
Swimming			Months	Per week	Minutes
Weight Lifting			Months	Per week	Minutes
Baseball			Months	Per week	Minutes
Basketball			Months	Per week	Minutes
Football			Months	Per week	Minutes
Racquetball			Months	Per week	Minutes
Handball			Months	Per week	Minutes
Tennis			Months	Per week	Minutes
Snow Skiing or Snowboarding			Months	Per week	Minutes
Water Skiing or Wave Runner			Months	Per week	Minutes
Other (please list)			Months	Per week	Minutes

9. Do you have hobbies that involve repetitive use of your hands (outside of work) such as any of the following?

Type of Hobby	Yes	No	Number of months per year	Average number of times per week	Average number of minutes each time
Computer, Internet			Months	Per week	Minutes
Knitting, Sewing, Needlepoint, Crocheting, Arts and Crafts			Months	Per week	Minutes
Gardening, Landscaping			Months	Per week	Minutes
Snow Shoveling			Months	Per week	Minutes
Maintenance (e.g. car or engine repair), Mechanical Work			Months	Per week	Minutes
Practicing or Playing the Piano			Months	Per week	Minutes
Other Musical Instruments (please specify)			Months	Per week	Minutes
Driving a motorcycle or ATV			Months	Per week	Minutes
Snowmobiling.			Months	Per week	Minutes
Woodworking, furniture building or repair			Months	Per week	Minutes
Remodeling or building a home			Months	Per week	Minutes
Using a chainsaw (e.g. cutting wood) or other vibrating tools			Months	Per week	Minutes
Other (please specify)			Months	Per week	Minutes
Other (please specify)			Months	Per week	Minutes

10. Are you currently:

- a. Pregnant?  Yes  No  
i. If yes, when is your due date  /  /   
Month Day Year
- b. Have your periods become irregular or stopped or have you experienced things such as hot flashes?  Yes  No  
i. If yes, for how many years?  Years  
ii. If yes, how long has it been since your last period?    
Month Year
- c. Have you used Estrogen replacement (or Hormone Replacement Therapy)  
 Yes  No  
i. If yes, how many years have you used Estrogen replacement or Hormone Replacement Therapy?  Years  
ii. Did you quit taking Estrogen replacement or Hormone Replacement in the past year?  Yes  No

11. Have you ever been told by a physician that you have any of the following:

- a. Diabetes:  Yes  No  
Approximately how many years ago was this diagnosed?  Years  
With which of the following are you treating the Diabetes?  
 Insulin  
 Pills / Oral Agents   
Both Insulin and Pills  Diet  
only ( no insulin or pills)
- b. Have you ever been diagnosed with Rheumatoid arthritis, Lupus, or another inflammatory arthritis (not typical Osteoarthritis or Degenerative Arthritis).  
 Yes  No  
Approximately how many years ago was this diagnosed?  Years

- c. Osteoarthritis or Degenerative Arthritis \_\_\_ Yes \_\_\_ No  
 i. If yes, what joints have been affected? (check all that apply)

<input checked="" type="checkbox"/>	Body Part	Which side is affected?			How many years ago was this diagnosed?
		Right	Left	Both	
<input type="checkbox"/>	Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Wrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years

- d. Thyroid problem: \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years
- e. Gout: \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years
- f. Kidney Failure: \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years
- g. High Blood Pressure: \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years
- h. High cholesterol (Laboratory test result over 200 mg/dL) \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years
- i. Other: \_\_\_\_\_(please specify) \_\_\_ Yes \_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_Years

- j. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- k. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- l. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- m. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- n. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- o. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- p. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- q. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- r. Other: \_\_\_\_\_ (please specify)    \_\_\_ Yes \_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years

12. Has any one in your family (blood relatives only) ever been diagnosed with Carpal Tunnel Syndrome?    \_\_\_ Yes    \_\_\_ No

13. What is your height?    \_\_\_ feet    \_\_\_ inches

14. What is your current weight?    \_\_\_ lbs.

15. What is the most you weighed in your life?    \_\_\_ lbs.

16. What was your weight when you were 20 years old?    \_\_\_ lbs.

17. Marital Status:

- Never married (Single)
- Currently married
- Divorced
- Separated
- Widowed

18. What is the highest grade in school that you completed?

- 8<sup>th</sup> grade or less
- Some high school
- High school graduate or GED
- Some college
- College graduate (Bachelor's Degree or higher)

19. How often do you have family problems that irritate or bother you?

- Never
- Occasionally
- Often
- Always

20. Have you ever smoked tobacco?

- Never
  - Yes, current
  - Yes, but smoked in the past
- If never, go to question 22...otherwise*
- How old were you when you started smoking? \_\_\_\_\_ years old
- How old were you when you quit smoking, if you quit? \_\_\_\_\_ years old
- On average, how many cigarettes did/do you smoke per day? \_\_\_\_\_

21. How many cups of caffeinated coffee do you drink in an average day?

- \_\_\_\_\_ Number of cups per day

22. How many 12 oz. glasses (one can) of caffeinated beverages (e.g. Coke, Pepsi) do you drink in an average day?

- \_\_\_\_\_ Number of glasses per day

23. Over the past year, how much alcohol do you drink in an average week?

(1 drink = 12 oz. beer, 6 oz. wine, or 1 oz. liquor)

- None
- 1-2 drinks per week
- 3-5 drinks per week
- 6-11 drinks per week
- 12-17 drinks per week
- 18-23 drinks per week
- 24-29 drinks per week
- 30 or more drinks per week

24. In the past, have you ever had a problem with alcohol?  Yes  No  
a. If yes, approximately how many years ago? \_\_\_\_\_ Years
25. How would you describe your general health compared to others of your own age?  
 Much Better  
 Somewhat Better  
 The Same  
 Somewhat Worse  
 Much Worse
26. How often during the past year have you felt “down”, blue or depressed?  
 Never  
 Seldom  
 Often  
 Always
27. How often are you physically exhausted after work?  
 Never  
 Seldom  
 Often  
 Always
28. How often are you mentally exhausted after work?  
 Never  
 Seldom  
 Often  
 Always
29. Do you get along with your co-workers?  
 Always  
 Often  
 Occasionally  
 Never
30. All in all, how satisfied are you with your job?  
 Very satisfied  
 Satisfied  
 Neither satisfied nor dissatisfied  
 Dissatisfied  
 Very dissatisfied

31. Does your supervisor demonstrate his or her appreciation for the work that you do?
- Always
  - Often
  - Occasionally
  - Never
32. How strongly would you recommend your job to someone else?
- Strongly recommend
  - Recommend
  - Neither recommend nor discourage
  - Discourage
  - Strongly discourage
33. If you were looking for a new job now, how likely is it that you would decide to take this job again?
- Very likely
  - Likely
  - Neither likely nor unlikely
  - Unlikely
  - Very unlikely
34. My employer cares about my health and safety on the job.
- Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly Disagree

***Thank you for completing the questionnaire.***

## Appendix B.2: Structured Interview

Plant: \_\_\_\_\_  
 Code # \_\_\_\_\_  
 Date: \_\_\_\_\_

### Baseline Structured Interview (to be completed on a laptop computer)

At the current time or at any time in the past month have you had any pain, ache, stiffness, numbness or tingling in any of the following body parts? (check all that apply and refer to the body diagram so the worker can note all areas that apply)

Body part	Yes	No	Symptoms in this body part	Pain / Ache / Burning / Stiffness	Pain Severity Rating (1-10)	Current Pain / Ache / Burning / Stiffness Symptoms	Total Pain Duration (days)	Tingling / Numbness	Current Numbness / Tingling Symptoms	Total Numbness / Tingling Duration (days)
1. Neck (A)				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
2. Shoulder										
Interscapular (D)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Nape of the Neck (C)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Periscapular (G)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Shoulder (Glenohumeral) (H)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Upper Arm (J)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Nape of the Neck (B)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Periscapular (F)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Shoulder (Glenohumeral) (E)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Upper Arm (I)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
3. Elbow										
R. Medial Elbow (N)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lateral Elbow (P)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Elbow (Other) (O)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Forearm (R)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days



1. (Computer selects the body part noted to have been affected in the prior question) In the past month, have you missed work or changed jobs because of problems with the \_\_\_\_\_ body part?

No Missed work, Lost time, or moved to another job.

Body part	Lost time / Missed work	Moved to another job	Number of Days missed work
1. Neck (A)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
2. Shoulder			
Interscapular (D)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Nape of the Neck (C)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Periscapular (G)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Shoulder (Glenohumeral) (H)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Upper Arm (J)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Nape of the Neck (B)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Periscapular (F)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Shoulder (Glenohumeral) (E)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Upper Arm (I)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
3. Elbow			
R. Medial Elbow (N)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lateral Elbow (P)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Elbow (Other) (O)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Forearm (R)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Medial Elbow (M)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Lateral Elbow (K)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Elbow (Other) (L)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days

L. Forearm (Q)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
4. Wrist			
R. Wrist (T)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Wrist (S)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
5. Hand			
R. thumb	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. index finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. middle/long finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. ring finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. 5 <sup>th</sup> /pinkie finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. thumb	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. index finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. middle/long finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. ring finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. 5 <sup>th</sup> /pinkie finger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Days

2. (For those indicating a history of numbness OR tingling in the hand/wrist/fingers in question #1):

How long all together have you had tingling and/or numbness? \_\_\_\_\_ months

Is or was the numbness or tingling in your hands (check all that apply)...

\_\_\_\_\_ worse at night

\_\_\_\_\_ present on awakening in the morning that resolves within 1/2 hour

\_\_\_\_\_ worse with holding an object (e.g., steering wheel, tool or newspaper)

\_\_\_\_\_ Intermittent

\_\_\_\_\_ Continuous If continuous how many months has it been continuous? \_\_\_\_\_ months

3. Do you ever have numbness and/or tingling in your...

Right foot/leg? \_\_\_\_\_ Yes \_\_\_\_\_ No

Left foot/leg? \_\_\_\_\_ Yes \_\_\_\_\_ No

4. Have you ever had snapping or locking of a finger? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, Which finger(s)? Right \_\_\_\_\_ Left \_\_\_\_\_

5. Have you ever been told by a medical doctor that you have/had any of the following disorders?

Disorder	Yes	No	Right, Left, Bilateral	Year of Diagnosis
Thoracic Outlet Syndrome				
Rotator Cuff Tear				
Rotator Cuff Tendinitis or Shoulder Tendinitis				
Lateral Epicondylitis (Tennis Elbow)				
Medial Epicondylitis (Golfer's Elbow)				
Cubital Tunnel Syndrome (Ulnar nerve problem at the elbow)				
DeQuervains				
Hand / Wrist / Forearm Fracture				
Hand/Wrist Tendinitis				
Carpal Tunnel Syndrome				
Raynaud's Disease				
Trigger Finger				

6. Have you ever had a pinched nerve (e.g. sciatica)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, was the pinched nerve in the back? \_\_\_\_\_ Yes \_\_\_\_\_ No

Was the pinched nerve in the neck? \_\_\_\_\_ Yes \_\_\_\_\_ No

7. Have you ever had a broken bone or fracture? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which did you fracture?

R. Clavicle \_\_\_\_\_ Yes \_\_\_\_\_ No

L. Clavicle \_\_\_\_\_ Yes \_\_\_\_\_ No

R. Humerus \_\_\_\_\_ Yes \_\_\_\_\_ No

L. Humerus \_\_\_\_\_ Yes \_\_\_\_\_ No

R. Radius  Yes  No  
 L. Radius  Yes  No  
 R. Ulna  Yes  No  
 L. Ulna  Yes  No  
 R. Wrist  Yes  No  
 L. Wrist  Yes  No  
 R. digit(s)  Yes  No  
 L. digit(s)  Yes  No

8. Have you ever dislocated a joint?  Yes  No

If yes, which joint(s) have you dislocated?

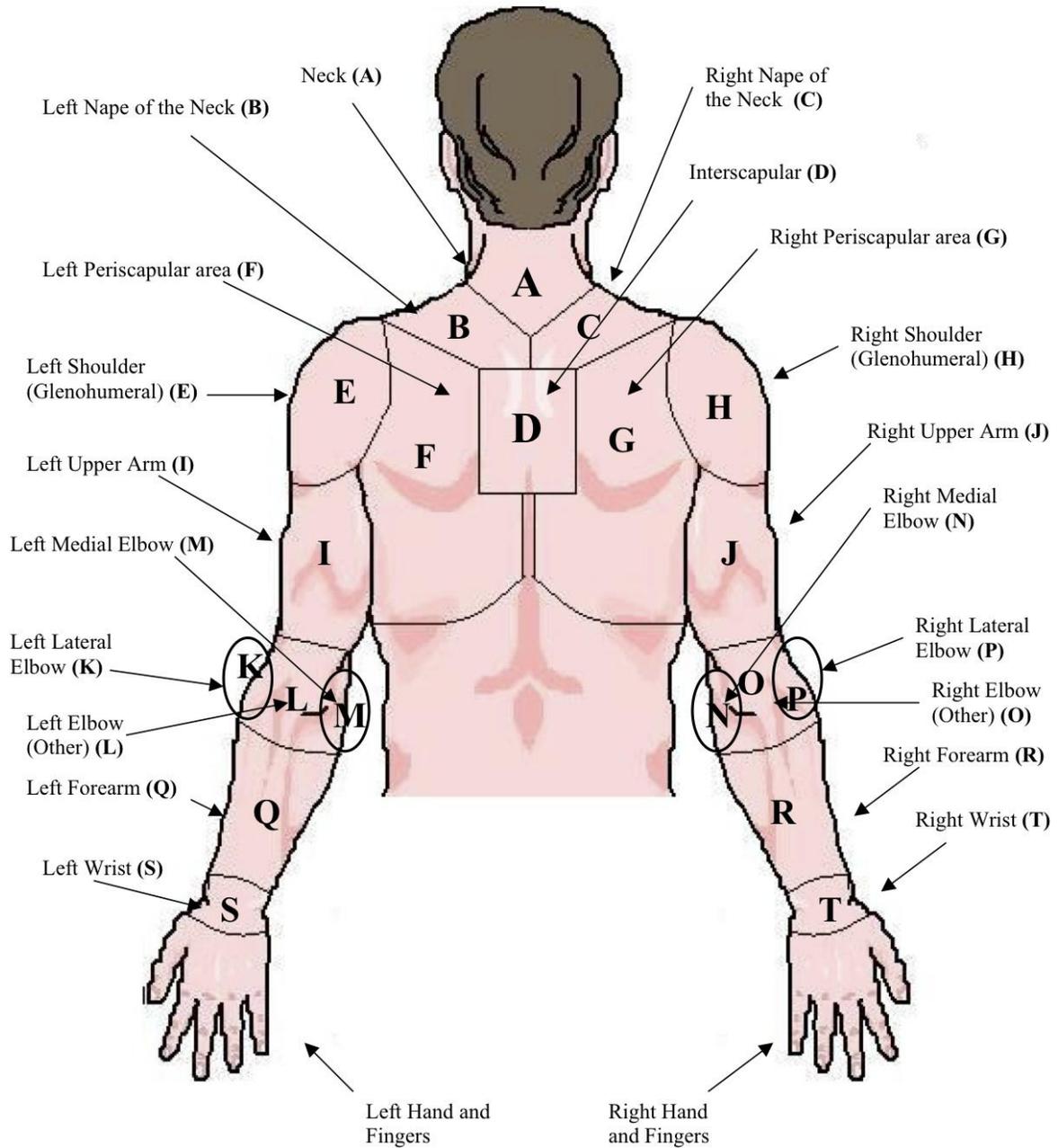
R. Shoulder  Yes  No  
 L. Shoulder  Yes  No  
 R. Elbow  Yes  No  
 L. Elbow  Yes  No  
 R. Wrist  Yes  No  
 L. Wrist  Yes  No  
 Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Have you ever had surgery other than dental, tonsillectomy, C-section or hernia repair?  Yes  No  
 If yes, what surgeries?  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Have you been hospitalized other than for surgery or childbirth?  Yes  No  
 If yes, for what problem(s) or diagnoses?  
 \_\_\_\_\_  
 \_\_\_\_\_

Appendix B.3: Sectioned Upper Extremity and Upper Torso Body Diagram

Body Diagram for Structured Interviews



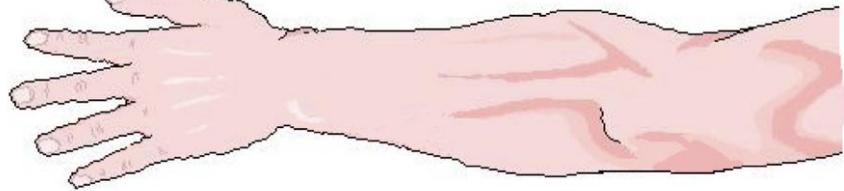
# Appendix B.4: Hand and Digit Pain Diagram

## Hand Symptoms Diagram

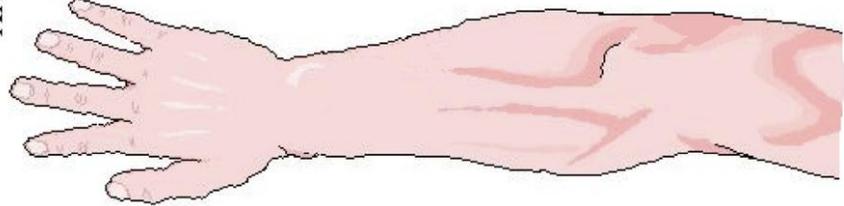
Plant: \_\_\_\_\_  
Code # \_\_\_\_\_  
Date: \_\_\_\_\_  
Examiner: \_\_\_\_\_

Please mark each area on your hand and arm where you are experiencing any pain, ache, burning, numbness and/or tingling. If you have any questions please ask. Please mark all hand diagrams with pertinent information.

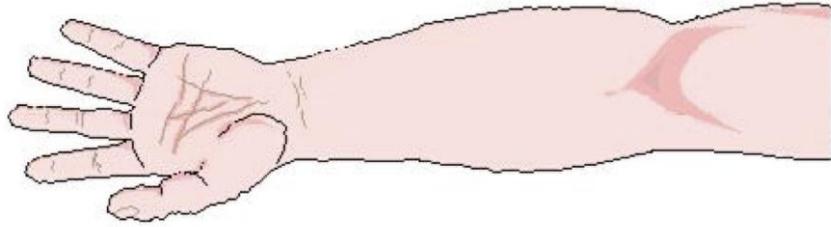
OOOO - Pain, Ache, Burning and/or Stiffness  
XXXXX - Numbness and/or Tingling



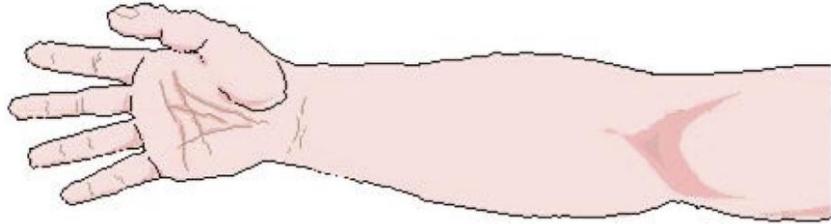
**Left**



**Right**



**Left**



**Right**



Plant: \_\_\_\_\_ Code # \_\_\_\_\_ Date: \_\_\_\_\_

Region	Sign	1st Examiner		2nd Examiner	
		+	-	+	-
		Abnormal	Normal	Abnormal	Normal
R. Elbow	Tender Point 1 (Retro Lateral Epicondyle)				
	Tender Point 2 (Lateral Epicondyle)				
	Tender Point 3 (Between Lateral Epicondyle and Radial Head)				
	Tender Point 4 (Radial Head)				
	Tender Point 5 (1 cm Distal to the Radial Head)				
	Tender Point 6 (Radial Tunnel)				
	Tender Medial Epicondyle				
	Tender 1 cm Distal to the Medial Epicondyle				
	Resisted Wrist / Phalangeal Extension (Lateral Epicondylitis pain/soreness/etc.)				
	Lateral epicondyle pain with resisted middle finger extension				
	Resisted Wrist / Phalangeal Flexion (Medial Epicondylitis pain/soreness/etc.)				
	Tinel's Retrocondylar Groove (to Distal Forearm)				
	Tinel's Cubital Tunnel (to Distal Forearm)				
	L. Elbow	Tender Point 1 (Retro Lateral Epicondyle)			
Tender Point 2 (Lateral Epicondyle)					
Tender Point 3 (Between Lateral Epicondyle and Radial Head)					
Tender Point 4 (Radial Head)					
Tender Point 5 (1 cm Distal to the Radial Head)					
Tender Point 6 (Radial Tunnel)					
Tender Medial Epicondyle					
Tender 1 cm Distal to the Medial Epicondyle					
Resisted Wrist / Phalangeal Extension (Lateral Epicondylitis pain/soreness/etc.)					
Lateral epicondyle pain with resisted middle finger extension					
Resisted Wrist / Phalangeal Flexion (Medial Epicondylitis pain/soreness/etc.)					
Tinel's Retrocondylar Groove (to Distal Forearm)					
Tinel's Cubital Tunnel (to Distal Forearm)					

↑ Mark All Positive Findings ↓

↑ Mark All Positive Findings ↓

Plant: \_\_\_\_\_ Code # \_\_\_\_\_ Date: \_\_\_\_\_

Region	Sign	1st Examiner		2nd Examiner	
		+	-	+	-
		Abnormal	Normal	Abnormal	Normal
R. Wrist	FCR – tenderness				
	FCU – tenderness				
	Flexor tendon- tenderness				
	1 <sup>st</sup> compartment tenderness				
	Tender over Extensor Compartment (not 1 <sup>st</sup> compartment)				
	If yes, which Compartment?				
	ECU tenderness				
	Resisted wrist flexion with pain at FCR				
	Resisted wrist flexion with pain at FCU				
	Resisted Phalangeal Flexion				
	Finkelstein’s (1 <sup>st</sup> Ext. Comp. pain/soreness/etc.)				
	Pain in Extensor Tendon with resisted Phalangeal extension (not 1 <sup>st</sup> compartment)				
	Pain in ECU with resisted extension				
	Phalen’s 60 second test ( $\geq 2$ median nerve digits)				
	Tinel’s Proximal Carpal Tunnel ( $\geq 2$ median nerve digits)				
	Tinel’s Mid-Carpal Tunnel ( $\geq 2$ median nerve digits)				
	Tinel’s Distal Carpal Tunnel ( $\geq 2$ median nerve digits)				
L. Wrist	FCR – tenderness				
	FCU – tenderness				
	Flexor tendon- tenderness				
	1 <sup>st</sup> compartment tenderness				
	Tender over Extensor Compartment (not 1 <sup>st</sup> compartment)				
	If yes, which Compartment?				
	ECU tenderness				
	Resisted wrist flexion with pain at FCR				
	Resisted wrist flexion with pain at FCU				
	Resisted Phalangeal Flexion				
	Finkelstein’s (1 <sup>st</sup> Ext. Comp. pain/soreness/etc.)				
	Pain in Extensor Tendon with resisted Phalangeal extension (not 1 <sup>st</sup> compartment)				
	Pain in ECU with resisted extension				
	Phalen’s 60 second test ( $\geq 2$ median nerve digits)				
	Tinel’s Proximal Carpal Tunnel ( $\geq 2$ median nerve digits)				
	Tinel’s Mid-Carpal Tunnel ( $\geq 2$ median nerve digits)				
	Tinel’s Distal Carpal Tunnel ( $\geq 2$ median nerve digits)				

Plant: \_\_\_\_\_ Code # \_\_\_\_\_ Date: \_\_\_\_\_

Region	Sign	1st Examiner		2nd Examiner	
		+	-	+	-
		Abnormal	Normal	Abnormal	Normal
R. Fingers	Thumb – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Index – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Middle finger – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Ring finger – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	5 <sup>th</sup> digit – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	CMC Deformity				
CMC Grind Test					
L. Fingers	Thumb – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Index – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Middle finger – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	Ring finger – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	5 <sup>th</sup> digit – A1 tenderness				
	Tendon Nodule				
	Locking / Triggering				
	CMC Deformity				
CMC Grind Test					

Plant: \_\_\_\_\_ Code # \_\_\_\_\_ Date: \_\_\_\_\_

7. Signs of Rheumatoid Arthritis    \_\_\_ Yes \_\_\_ No  
 8. Heberden's Nodes                    \_\_\_ Yes \_\_\_ No  
    If yes, which joint(s) \_\_\_\_\_  
 9. Bouchards Nodes                    \_\_\_ Yes \_\_\_ No  
    If yes, which joint(s) \_\_\_\_\_

- |                             | <b>Right</b>   | <b>Left</b>    |
|-----------------------------|----------------|----------------|
| 10. Dorsal Wrist Ganglia    | ___ Yes ___ No | ___ Yes ___ No |
| 11. Volar Wrist Ganglia     | ___ Yes ___ No | ___ Yes ___ No |
| 12. Dupuytren's contracture | ___ Yes ___ No | ___ Yes ___ No |

**Other findings in the physical exam:**

Body Part	Test performed	Positive finding	Negative finding	Examiner	
				1 <sup>st</sup>	2 <sup>nd</sup>

**Current Musculoskeletal Disorder(s)**

Right	Left	Diagnostic Impression

**Prior/Past Musculoskeletal Disorder(s)**

Right	Left	Diagnostic Impression

# Appendix B.6: Nerve Conduction Form

Plant: \_\_\_\_\_  
 Subject ID # \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Examiner: \_\_\_\_\_

## Nerve Conduction Data Form

<b>Right Hand</b>	
<b>Transcarpal</b>	<b>Motor</b>
Distance 8 cm ( )	Distance 8 cm ( )
Median Latency (msec)	Median Latency (msec)
Median Amplitude (µVs)	Median Amplitude (K)
Ulnar Latency (msec)	Ulnar Latency (msec)
Ulnar Amplitude (µVs)	Ulnar Amplitude (K)
Comments	Comments
<b>Digital Sensory</b>	
Distance 14 cm ( )	Distance 14 cm ( )
Median Latency (msec)	Median Latency (msec)
Median Amplitude (µVs)	Median Amplitude (K)
Ulnar Latency (msec)	Ulnar Latency (msec)
Ulnar Amplitude (µVs)	Ulnar Amplitude (K)
Comments:	Comments
<b>Left Hand</b>	
<b>Transcarpal</b>	<b>Motor</b>
Distance 8 cm ( )	Distance 8 cm ( )
Median Latency (msec)	Median Latency (msec)
Median Amplitude (µVs)	Median Amplitude (K)
Ulnar Latency (msec)	Ulnar Latency (msec)
Ulnar Amplitude (µVs)	Ulnar Amplitude (K)
Comments	Comments
<b>Digital Sensory</b>	
Distance 14 cm ( )	Distance 14 cm ( )
Median Latency (msec)	Median Latency (msec)
Median Amplitude (µVs)	Median Amplitude (K)
Ulnar Latency (msec)	Ulnar Latency (msec)
Ulnar Amplitude (µVs)	Ulnar Amplitude (K)
Comments	Comments

Hand Dorsum Temperature = 32° C  
 Median Digital Sensory → Long Finger  
 Ulnar Digital Sensory → Little Finger  
 If transcarpal delta ≥ 0.4 msec, do ulnar digital sensory and ulnar motor  
 If median motor latency or amplitude abnormal, map E1. If still abnormal, do median/ulnar with forearm conduction  
 If mapping needed for motor studies, note both original and mapped numbers in comments.

Appendix B.7: Pain Scale

