HAND & WRIST FUNCTIONAL STATUS SCALE

Patient Name:_____ **Date:**_____

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…….	0	1	2	3	4
Buttoning of clothes……	0	1	2	3	4
Holding a book while reading…….	0	1	2	3	4
Gripping a telephone handle……	0	1	2	3	4
Opening jars……	0	1	2	3	4
Household chores……	0	1	2	3	4
Carrying grocery bags…….	0	1	2	3	4
Bathing and dressing……	0	1	2	3	4

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