



Queensland  
Government

Metro North Hospital and Health Service

**BOSTON CARPAL TUNNEL  
QUESTIONNAIRE  
FUNCTIONAL STATUS  
SCALE**

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex:  M  F  I

On a typical day in the past two weeks, have hand or wrist symptoms caused you to have any difficulty completing the activities listed below?

Please tick one number that best describes your ability to do the activity.

Left hand

Right hand

Activity	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Cannot do at all due to symptoms
Writing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Buttoning of clothes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Holding a book while reading	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Gripping of a telephone handle	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Opening of jars	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Household chores	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Carrying of grocery bags	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Bathing and dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**Clinician use only:**

SCORE: ..... (Total Score) / 8 = ..... (Average Score)

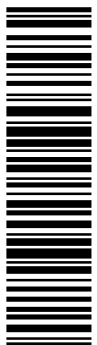
Completed by (*print name*): ..... Designation: .....

Signature: ..... Date: ..... / ..... / .....

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