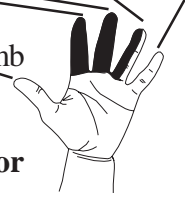


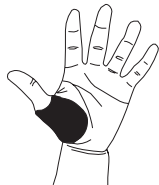
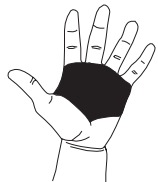
The shaded areas in the diagrams below show the position of the body parts referred to in the questionnaire. Please answer by marking the appropriate box.

Index Middle Ring Pinkie

Thumb



Complete only for LEFT HAND



During the last work week how often did you experience ache, pain, discomfort in:

If you experienced ache, pain, discomfort, how uncomfortable was this?

If you experienced ache, pain, discomfort, did this interfere with your ability to work?

<p>Area A (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Area B (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Area C (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Area D (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Area E (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Area F (Shaded area)</p>	<p>Never 1-2 3-4 Once Several times times times every times last last last every every week week day day <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Slightly Moderately Very uncomfortable uncomfortable uncomfortable <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Not at all Slightly Substantially interfered interfered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>