

Patient Shoulder Questionnaire

(Done by office staff) Age: _____ Weight: _____ Ht: _____ BP: _____ P: _____

NAME: _____ DATE: _____ Sex: M/F (Circle)

Email Address: _____ May we contact you by email? Y / N

Occupation _____ Referring physician _____

Which hand do you write with R / L or throw with R / L? (Circle)

1. Which shoulder is the problem: R / L? (Circle)

2. When did the pain start? _____

3. Was there any traumatic event? If so, when/what was the injury?

4. Have you seen another physician for this problem? Who? _____

5. Have you had this problem before? How was it treated (sling, therapy, etc.)?

6. Have you DISLOCATED your SHOULDER before? How? When?

How many times? _____ Any treatment? _____

7. Have you had any injections into your shoulder? _____

If so, how many times and when was the last time? _____

8. Have you had any shoulder surgery? Which shoulder? What was done? _____

9. What medicines do you take ***for your Shoulder pain*** (list medication, dose & frequency)? _____

10. Do you have arthritis of your knee(s) or hip(s)? (Circle each)

SYMPTOMS:

1. Does your shoulder pain awaken you at night? _____

2. Do you have pain All, MOST, or only SOME of the time? (Circle)

3. What makes the pain worse? _____ better? _____

4. Does the pain interfere with sleep? _____ work? _____ sports? _____

5. Does pain happen BEFORE, DURING or AFTER sports/activities? (Circle)

6. Any NUMBNESS, TINGLING, or a PINS-AND-NEEDLES feeling in your arm or hand? _____ When? _____

7. What treatment have you previously had for your shoulder (therapy, sling, etc...)?

8. Have you missed any work due to this injury? -If so, how long?

9. Do you have any NECK PAIN? Where? _____

10. What sports to you participate in?

SPORT	LEVEL(Pro, comp, hobby?)	HRS/WK	WKS/YR
<i>Ex. Football</i>	<i>high school</i>	<i>8/wk</i>	<i>14</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Shoulder Questionnaire

Rate your shoulder pain (Circle one):

None-5, slight-4, After normal activity-3, Moderate-2, Marked-1, Completely Disabled-0

Describe the FUNCTION of your shoulder in the following activities **by entering the number which corresponds to your functional level.**

4 = normal, 3 = mild compromise, 2 = difficulty, 1 = with aid, 0= unable

- a. use back pocket (male), fasten bra (female) _____
- b. Perineal care (groin area) _____
- c. Wash opposite axilla (armpit) _____
- d. Eat with utensil _____
- e. Comb hair _____
- f. Use hand with arm at shoulder level _____
- g. Use hand overhead _____
- h. Carry 10 to 15 lb (e.g., grocery bag) with arm at side
- i. Dress _____
- j. Sleep on affected side _____
- k. Pulling _____
- l. Throwing _____
- m. Lifting _____
- n. Do usual work _____ (specify type of work) _____
- o. Do usual sport _____ (specify type of sport) _____