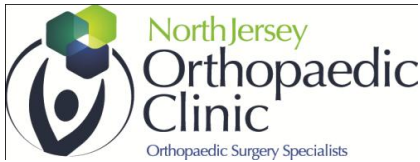


# PATIENT SHOULDER QUESTIONNAIRE



BP ____ / ____	Pulse ____	Temp ____
Resp _____		

Name \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Chart # \_\_\_\_\_ Sex:  Male  Female

\*Problem With:  Right  Left  Both – Which worse  Right  Left

I am :  Right handed  Left handed  Ambidextrous

### Work History:

Occupation: \_\_\_\_\_ Is Problem **Work Related**?  Yes  No If work injury, Date: \_\_\_\_\_

### Are you presently working?

Yes Are you presently on modified duty?  Yes  No

No Unemployed, since \_\_\_\_\_ Off work, since \_\_\_\_\_ Last day worked? \_\_\_\_\_

If you are **not** working, is it due to your shoulder problem?  Yes  No

**OR** is it because you are  Retired  A Student  A Homemaker  Disabled  Other

**Is this problem related to a motor vehicle accident?**  Yes Date: \_\_\_\_\_  No

Is there an attorney involved with your worker compensation or auto accident claim?  Yes  No

Attorney: \_\_\_\_\_

### \*I am having problems with: (Mark all that apply)

<input type="checkbox"/> Pain at rest	<input type="checkbox"/> Pain with use of arm	<input type="checkbox"/> Instability (Shoulder pops out)
<input type="checkbox"/> Stiffness (Loss of motion)	<input type="checkbox"/> Weakness	<input type="checkbox"/> Grinding / Popping
<input type="checkbox"/> Catching / Locking	<input type="checkbox"/> Loss of work	<input type="checkbox"/> Loss of activity / sport
<input type="checkbox"/> Swelling		

### Other Problems That Apply:

Neck  Back  Arthritis  Nerve Problems  Heart  Lung  Circulation  Other

### Do you have...

Neck Pain  Trigger Points  Upper Back Pain  Trapezius Pain  Radiation of Pain

Where does pain radiate? \_\_\_\_\_

The Problem is getting  Better  Worse  No better / No worse .

### Onset of the Problem:

Gradually, since \_\_\_\_\_ Describe: \_\_\_\_\_

Suddenly but without injury, on \_\_\_\_\_ Describe: \_\_\_\_\_

**Injury**, on \_\_\_\_\_ Occurred while:  Throwing  Lifting  Falling  Skiing  Snowboarding  
 Other Sport \_\_\_\_\_  Other \_\_\_\_\_  Don't know how I got this problem

Describe Injury: \_\_\_\_\_

**Prior Treatment For This Problem:**

Yes  No If yes, Treated by:  ER  Family MD  Orthopedic MD  PT  Chiropractor  Self

If previously treated, what was the diagnosis? \_\_\_\_\_ Physician \_\_\_\_\_

Type of Prior Treatment	How often?	Over how long?	Help	Hurt	No Effect	Comments?
Physical Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-inflammatories			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Advil <input type="checkbox"/> Alleve <input type="checkbox"/> Rx
Cortisone Injections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many total? _____
Rest			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropractic			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Massage Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acupuncture			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Have you had other problems with your shoulders in the past?  Yes  No If yes, please describe: \_\_\_\_\_

**Previous Shoulder Surgery:**  Yes  No If yes, please complete lines below for each surgery:

Month/Day/Year	Doctor's Name:	Type:	Results:
1) _____	_____	_____	_____
2) _____	_____	_____	_____

**Previous X-Rays:**  Yes  No If yes, please list the date, location and results below (if you know):

Month/Day/Year	Location (Hospital/ER/Office/Doctor/City)	Results:
1) _____	_____	_____
2) _____	_____	_____

**Previous MRI / Arthrogram / Ultrasound / CAT Scan:**  Yes  No If yes, please complete lines below (if you know):

Month/Day/Year	Location (Hospital/ER/Office/Doctor/City)	Type of Study (MRI etc.)	Results:
1) _____	_____	_____	_____
2) _____	_____	_____	_____

**PAIN:**

If you are not experiencing pain, then skip this section and go to "Instability" top of page 4:

**\*Quality of Pain:**

<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aching	<input type="checkbox"/> Burning

**\*Location of Pain:**

<input type="checkbox"/> Cannot locate exact spot	<input type="checkbox"/> Front	<input type="checkbox"/> Side
<input type="checkbox"/> Back	<input type="checkbox"/> Arm pit	<input type="checkbox"/> Top side
<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand	<input type="checkbox"/> AC joint
		<input type="checkbox"/> Other _____



**INSTABILITY:**

(If your shoulder does not “go out of place”, skip this section).

**My Shoulder Goes Out:**

<input type="checkbox"/> At the time of the original injury	<input type="checkbox"/> Regularly	<input type="checkbox"/> With major injury or stress
<input type="checkbox"/> With simple movements	<input type="checkbox"/> Partially then goes back in	<input type="checkbox"/> Never but feels like it might

Complete dislocations occur how often? \_\_\_\_\_ Total number of dislocations \_\_\_\_\_

Date first dislocation: \_\_\_\_\_ Date last dislocation: \_\_\_\_\_

Does your shoulder hurt when its not out of place?  No  Occasionally  Frequently  Mild  Moderate

Are you able to intentionally slip your shoulder out of place?  Yes  No

Have you required help to put shoulder back in?  Yes  No Explain: \_\_\_\_\_

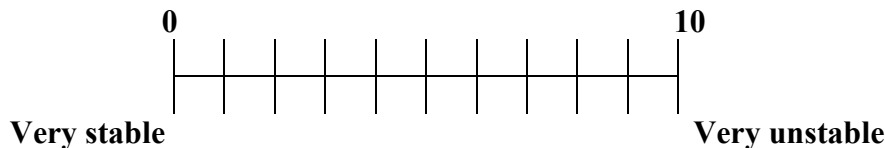
Have you been able to put the shoulder back in by yourself?  Yes  No Explain: \_\_\_\_\_

The shoulder goes back in:  Easily  With moderate difficulty  With great difficulty .

Describe shoulder position when it goes out: \_\_\_\_\_

Where does the shoulder go out?  Front  Back  Armpit  Not sure

**How unstable is your shoulder (mark line)?**



**PLEASE SIGN:** The information is accurate to the best of my knowledge. \_\_\_\_\_

<b>For Office use only</b>	Complete _____	Date ____ / ____ / ____
MD/PA _____	Date: _____	Clinician _____ Date: _____