SHOULDER QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which shoulder(s) did you hurt? _____

2.) Is this a new presentation of shoulder pain, or a follow-up?_____

3.) Did another provider refer you? If yes, who?_____

4.) What is your hand dominance?

__ambidextrous __left hand dominant __right hand dominant __no dominance

5.) Describe **how** and **where** your symptoms occurred/how you injured your shoulder? Be specific (include **dates**)

_____

_____

6.) What best describes your shoulder pain? (check all that apply)

__aching	__constant	__grinding	__sharp
__acute	__cramp-like	__improving	__stabbing
__acute on chronic	__diminishing	__intermittent	__staying the same
__burning	__dull	__pins and needles	__tender to touch
__catching	__electric	__popping	__throbbing
__chronic	__giving way	__progressive	__worsening
__clicking	__gradual	__radiating	other:_____

7.) What is associated with your shoulder pain? (check all that apply)

__arm pain	__hand numbness	__neck pain	__worse with forward elevation
__arm weakness	__hand tingling	__stiffness	__worse with overhead activity
__difficulty sleeping	__instability	__swelling	__worse with rotation
__elbow pain	__limited ROM	__upper back pain	other:_____

8.) Describe the timing of your pain? (check all that apply)

__began today	__occurs episodically	__occurs randomly	other:_____
__constantly occurs	__occurs in the morning	__occurs when sleeping on shoulder	
__occurs at night	__occurs intermittently	__occurs with activity	

9.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___ /10 on a bad day ___ /10 on an average day ___ /10

initially ___ /10 on a good day ___ /10

10.) How long have you had your shoulder pain? ___years ___months ___weeks ___days

11.) What are you currently using to treat the shoulder pain? (check all that apply)

__activity modification	__anti-inflammatory meds	__ injections	__no treatment
__Lidocaine patches	__physical therapy	__topical cream	other:_____
__muscle relaxants	__pilates	__Tylenol	
__narcotics/pain meds	__sling	__yoga	

12.) Have you had any procedures or surgeries to treat the shoulder pain? If yes, what type?

_____

13.) What tests have you had for this problem? (check all that apply)

__MRI __wound cultures other:_____

__plain radiographs (X-ray) __no tests

14.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __inability go to school __working light duty

__difficulty lifting heavy objects __inability to work __working on a limited basis

__difficulty with ADL's __problems sleeping __no limitations

__difficulty with REC participation __requiring constant assistance other: _____

__functional limitations __requiring occasional assistance

15.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:_____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date

Recall Review Signatures:		Date:
1		
2		
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