SHOULDER Survey Packet for Measuring Your Improvement

YOUR NAME: _____ **DATE:_____**

Record number: _____

Surgeon: Dr. John Skedros

A. How bad is your pain today (mark line with an **X**)?

_____

No pain at all Pain as bad as it can be

B. How bad is your pain on a typical day (mark line with an **X**)?

_____

No pain at all Pain as bad as it can be

C. Does your shoulder feel unstable (as if it were going to dislocate)? Yes or No

D. How unstable is your shoulder (mark line with an **X**)?

_____

Very Stable Very **Un**stable

E. Circle the number in the box that indicates your ability to do the following activities:

0 = Unable to do; **1** = Very difficult; **2** = Somewhat difficult; **3** = Not difficult

		Left Shoulder	**Right Shoulder**
1.	Put on a coat	0 1 2 3	0 1 2 3
2.	Sleep on your side	0 1 2 3	0 1 2 3
3.	Wash your back/do up a bra	0 1 2 3	0 1 2 3
4.	Manage toileting	0 1 2 3	0 1 2 3
5.	Comb Hair	0 1 2 3	0 1 2 3
6.	Reach high shelf	0 1 2 3	0 1 2 3
7.	Lift 10 lbs above shoulder	0 1 2 3	0 1 2 3
8.	Throw ball overhand	0 1 2 3	0 1 2 3
9.	Do usual work- list:	0 1 2 3	0 1 2 3
10.	Do usual sport- list:	0 1 2 3	0 1 2 3

Please fill out the remainder of this survey. 

Record No. _____ Date _____

Simple Shoulder Test

Please answer each question below by circling “yes” or “no” (please do not leave questions unanswered)

1. Is your shoulder comfortable with your arm at rest by your side?	**Yes**	**No**
2. Does your shoulder allow you to sleep comfortably?	**Yes**	**No**
3. Can you reach the small of your back to tuck in your shirt with your hand?	**Yes**	**No**
4. Can you place your hand behind your head with the elbow straight out to the side?	**Yes**	**No**
5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	**Yes**	**No**
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	**Yes**	**No**
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	**Yes**	**No**
8. Can you carry twenty pounds at your side with the affected extremity?	**Yes**	**No**
9. Do you think you can toss a softball underhand ten yards with the affected extremity?	**Yes**	**No**
10. Do you think you can toss a softball overhand ten yards with the affected extremity?	**Yes**	**No**
11. Can you wash the back of your opposite shoulder with the affected extremity?	**Yes**	**No**
12. Would your shoulder allow you to work full-time at your regular job?	**Yes**	**No**

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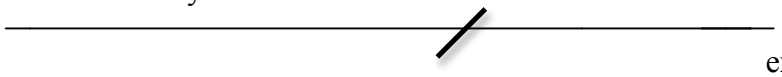
THE WESTERN ONTARIO ROTATOR CUFF INDEX
(WORC)

Section A: Physical Symptoms
INSTRUCTIONS TO PATIENTS

The following questions concern the physical symptoms you have experienced due to your shoulder problem. In all cases, please enter the amount of symptom you have experienced in the past week. (Please mark your answers with a slash "/")

Here is an example of how to mark the line

0. How painful is it for you to run?



no pain — extreme pain

START HERE

1. How much sharp pain do you experience in your shoulder?

no pain — extreme pain

2. How much constant, nagging pain do you experience in your shoulder?

no pain — extreme pain

3. How much weakness do you experience in your shoulder?

no weakness — extreme weakness

4. How much stiffness do you experience in your shoulder?

no weakness — extreme weakness

5. How much clicking, grinding or crunching do you experience in your shoulder?

none — extreme

6. How much discomfort do you experience in your neck because of your shoulder?

no discomfort — extreme discomfort

SECTION B: Sports/Recreation
INSTRUCTIONS TO PATIENTS

The following section concerns how your shoulder problem has affected your sports or recreational activities in the past week. For each question, please mark your answers with a slash "/".

7. How much has your shoulder affected your fitness level?

not affected — extremely affected

8. How much has your shoulder affected your ability to throw hard or far?

not affected — extremely affected

9. How much difficulty do you have with someone or something coming into contact with your affected shoulder?

no fear — extremely fearful

10. How much difficulty do you experience doing push-ups or other strenuous shoulder exercises because of your shoulder?

no difficulty — extreme difficulty

SECTION C: Work
INSTRUCTIONS TO PATIENTS

The following section concerns the amount that your shoulder problem has affected your work around or outside of the home. For each question, please mark your answers with a slash "/".

11. How much difficulty do you experience in daily activities about the house or yard?

no difficulty — extreme difficulty

12. How much difficulty do you experience working above your head?

no difficulty — extreme difficulty

13. How much do you use your uninvolved arm to compensate for your injured one?

not at all — constant

14. How much difficulty do you experience lifting heavy objects from the ground or below shoulder level?

no difficulty — extreme difficulty

SECTION D: Lifestyle
INSTRUCTIONS TO PATIENTS

The following section concerns the amount that your shoulder problem has affected or changed your life style. Please indicate the appropriate amount for the past week with a slash "/".

15. How much difficulty do you have sleeping because of your shoulder?

no difficulty — extreme difficulty

16. How much difficulty have you experienced with styling your hair because of your shoulder?

no difficulty — extreme difficulty

17. How much difficulty do you have "roughhousing or horsing around" with family or friends?

no difficulty — extreme difficulty

18. How much difficulty do you have dressing or undressing?

no difficulty — extreme difficulty

SECTION E: Emotions
INSTRUCTIONS TO PATIENTS

The following questions relate to how you have felt in the past week with regard to your shoulder problem.

19. How much frustration do you feel because of your shoulder?

no frustration — extreme frustration

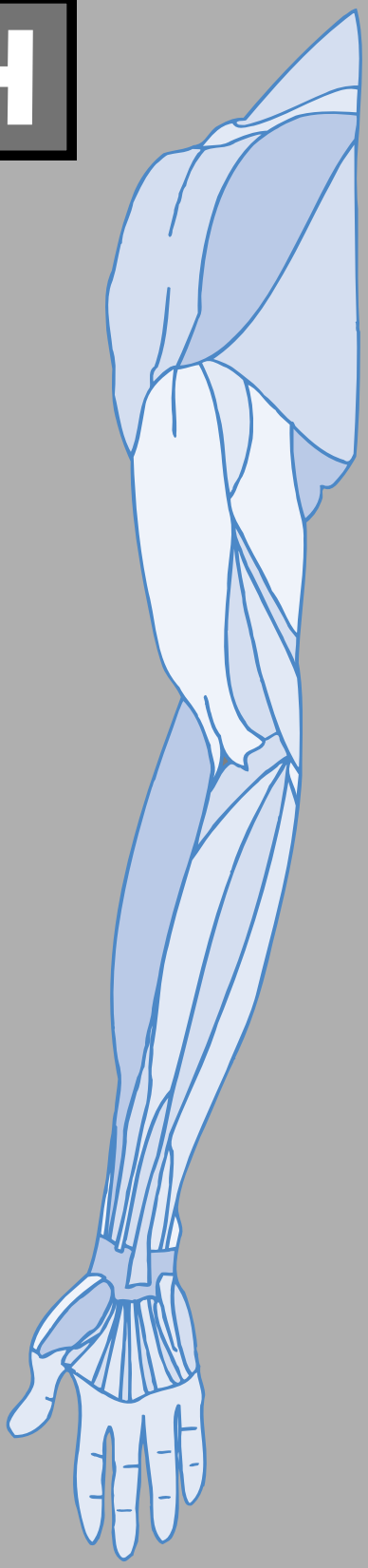
20. How "down in the dumps" or depressed do you feel because of your shoulder?

none — extreme

21. How worried or concerned are you about the effect of your shoulder on your occupation or work?

not at all — extremely concerned

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\frac{(\text{sum of n responses})}{n} - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	using your usual technique for your work?	1	2	3	4	5
2.	doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3.	doing your work as well as you would like?	1	2	3	4	5
4.	spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	using your usual technique for playing your instrument or sport?	1	2	3	4	5
2.	playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3.	playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4.	spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

SF-36 QUESTIONNAIRE

Patient Name:_____ **Date:**_____

1. In general, would you say your health is: (circle one)

Excellent Very good Good Fair Poor

2. Compared to one year ago, how would you rate your health in general now? (circle one)
   Much better now than one year ago.
   Somewhat better now than one year ago.
   About the same as one year ago.
   Somewhat worse than one year ago.
   Much worse than one year ago.

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Mark each answer with an X)

ACTIVITIES	Yes Limited A Lot	Yes Limited A Little	No, Not Limited At All
a. **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports			
b. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
c. Lifting or carrying groceries			
d. Climbing **several** flights of stairs			
e. Climbing **one** flight of stairs			
f. Bending, kneeling or stooping			
g. Walking **more than a mile**			
h. Walking **several blocks**			
i. Walking **one block**			
j. Bathing or dressing yourself			

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Mark each answer with an X)

	YES	NO
a. Cut down on the **amount of time** you spent on work or other activities		
b. **Accomplished less** than you would like		
c. Were limited in the **kind** of work or other activities		
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)		

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Mark each answer with an X)

	YES	NO
a. Cut down on the **amount of time** you spent on work or other activities		
b. **Accomplished less** than you would like		
c. Didn't do work or other activities as **carefully** as usual		

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (circle one)

Not at all Slightly Moderately Quite a bit Extremely

7. How much bodily pain have you had during the past 4 weeks? (circle one)

None Very Mild Mild Moderate Severe Very severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks: (Mark each answer with an X)

	All of the Time	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
a. Did you feel full of pep?						
b. Have you been a very nervous person?						
c. Have you felt so down in the dumps that nothing could cheer you up?						
d. Have you felt calm and peaceful?						
e. Did you have a lot of energy?						
f. Have you felt downhearted and blue?						
g. Did you feel worn out?						
h. Have you been a happy person?						
i. Did you feel tired?						

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (circle one)

All of the time Most of the time Some of the time A little of the time None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
a. I seem to get sick a little easier than other people					
b. I am as healthy as anybody I know					
c. I expect my health to get worse					
d. My health is excellent					

You have reached the end of this survey. Thank you for your participation!