

UTAH ORTHOPAEDIC SPECIALISTS

Shoulder Questionnaire

Name: _____ Date: _____

CIRCLE ONE: right handed left handed

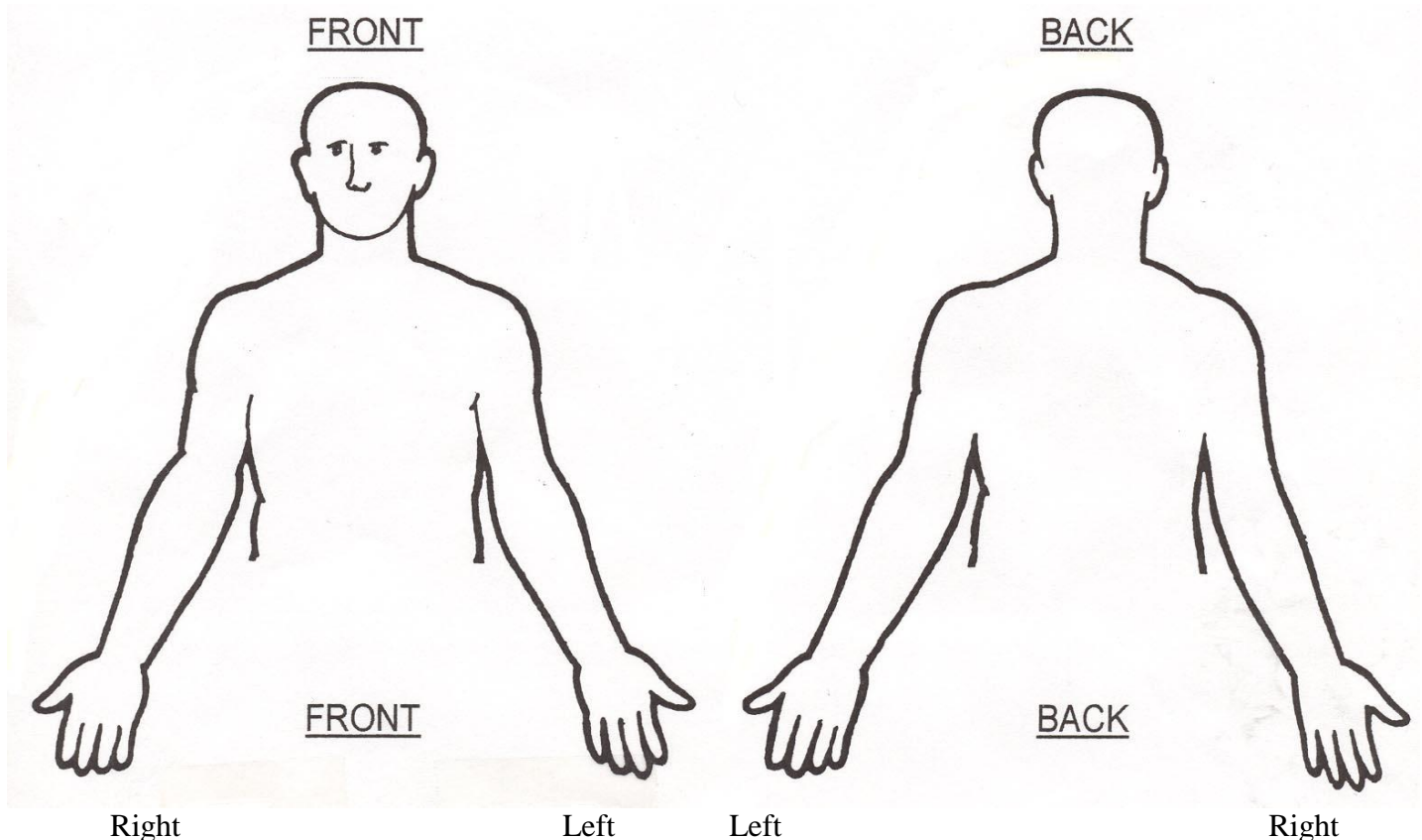
1. Do you have a history of a deep vein clot or pulmonary embolism? _____
2. What happened to your shoulder? _____

3. Which shoulder? L or R
4. When did it happen? Date: _____
5. How long have you had pain? Years: _____ Months: _____ Weeks: _____
6. What activities cause pain in your shoulders? _____

7. Does your shoulder slip out of joint ("dislocate") Yes or No
If so, what activities cause your shoulder to dislocate? _____
How many times has it dislocated in the past year? _____

8. Please draw the location of your pain on the body outlines using the following key:

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	===	ooo	xxx	///



SEE OTHER SIDE



Name: _____

9. What treatment have you had in the past (include physical therapy)? _____
10. Are you (please circle) better, worse, or the same since your treatment began? _____
11. Do you have pain in your shoulder at night? Yes or No
12. Have you ever had any surgery done on your shoulder? Yes or No
13. Have you ever had a cortisone injection in your shoulder? Yes or No
If so, how many times? _____
When were the shots given? Date: _____
14. What athletic activities do you participate in? Please list: _____
15. Are you taking any pain medications? If so, please list: _____
16. How many pain pills do you take each day? _____
17. Are you ALLERGIC to any medications? If so, please list: _____
18. Who referred you to this office? _____
19. How bad is your pain today (mark line with an **X**)?

No pain at all

Pain as bad as it can be

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

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

Very Stable

Very Unstable

21. 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 a 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