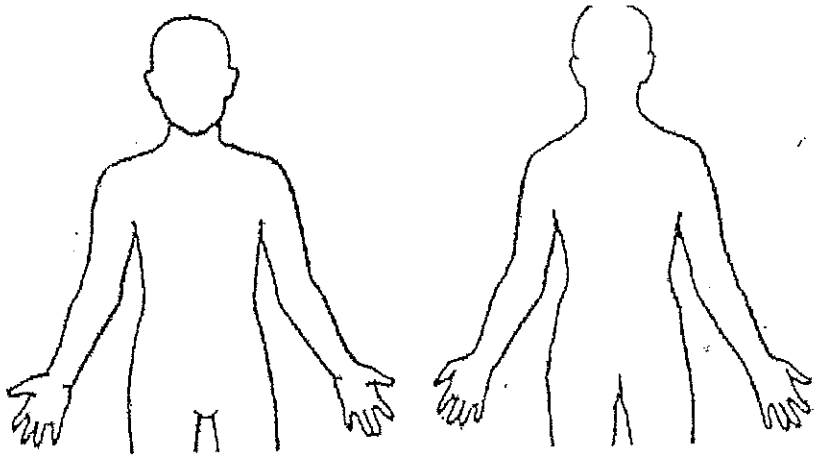
Date: ____/____/____ Name: _____

Shoulder Questionnaire

Place xxx's on area of pain



Front **Back**

How long has it been bothering you?

# of ____days ____weeks ____months ____years

How severe is the pain at its best and worst? (0 – no pain, 10 – most pain)

____best ____worst

Have you had this problem before?

____yes ____no if yes, when? _____

How did it start? (check all that apply)

____sports injury ____work injury ____overuse ____fall ____auto accident

____spontaneous (unknown)

Do you have the following? (check all that apply)

____nighttime pain ____painful popping ____coming out of joint ____weakness

____swelling ____unable to reach above shoulder ____numbness down arm ____stiffness

____neck pain ____pain with driving

Which doctors have you seen so far? (check all that apply)

____ER ____PCP ____Work doctor ____Another Orthopaedic Surgeon ____Chiropractor

What treatments have you had? (check all that apply)

____medications ____heat/ice ____creams/rubs ____physical therapy ____injections

____surgery

What is your goal for the appointment today? (check all that apply)

____find diagnosis ____make sure not damaging shoulder ____fix problem ____injection(s)

____schedule surgery ____second opinion