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SHOULDER QUESTIONNAIRE

DATE OF VISIT:_____ PATIENT NAME:_____

At baseline, what did/do you do for exercise and how often did/do you do each activity: _____
_____

Are you ☐ RIGHT or ☐ LEFT hand-dominant? (Which hand do you write with?)
Which shoulder is bothering you? ☐ RIGHT ☐ LEFT ☐ BOTH (which is worse: _____)
When did the pain begin? _____
Cause of pain: ☐ Gradual onset ☐ Sports injury ☐ Accident ☐ Work comp injury
If an injury occurred, describe what happened and when?

Any prior significant issues with that shoulder: ☐ No ☐ Yes

- Describe any previous injury_____
- List any previous surgeries (when, what, and surgeon's name): _____
- List any previous injections (when and with whom): _____

Frequency of pain: ☐ Constant ☐ Intermittent
Pain level at rest, i.e. when not moving (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)
Highest level of pain (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)

Do you have neck pain?: ☐ No ☐ Yes
Do you have pain radiating down your arm, below the level of the elbow: ☐ No ☐ Yes
Do you have numbness or tingling in that hand?: ☐ No ☐ Yes
Have you had neck surgery or injections?: ☐ No ☐ Yes (describe when/what):

Describe the pain : ☐ Aching ☐ Sharp ☐ Constant aching with sharp pain on movement
Do you feel : ☐ Grinding ☐ Catching ☐ Locking ☐ Clicking ☐ Popping ☐ Snapping
Do symptoms occur while: ☐ Lifting ☐ Reaching over shoulder level ☐ Reaching behind
When is pain the worst: ☐ Morning ☐ At the end of the day ☐ Trying to get to sleep
Is it hard to fall sleep?: ☐ No ☐ Yes
Does pain wake you from sleep?: ☐ No ☐ Yes
What bothers you most about your shoulder: ☐ Pain ☐ Decreased range of motion ☐ Weakness

Have you tried any of the following to relieve pain: ☐ Rest ☐ Heat ☐ Cold ☐ Home exercises
☐ Massage ☐ Sling ☐ Acupuncture
If you have had Physical Therapy: What facility: _____; How many sessions: _____
When was the last session: _____
List any medications taken for shoulder pain (name, dosage, and frequency): _____

Are you getting: ☐ Better ☐ Worse ☐ No change