Shoulder Pain Questionnaire

Name_________________________

Which shoulder is bothering you? Left Right Both

Are you left handed or right handed? Left Right

What type of work do you do? _______________________________________________

Did your shoulder pain start with a specific injury? Yes No

If yes: Date of injury: ___________________________

Mechanism of injury: ______________________________________________________

Did you feel a pop or snap with the injury: Yes No

Is the injury work related: Yes No

If there was no injury, did the pain start with a particular activity (such as baseball, tennis, painting, etc.)? Yes No

If yes, what started the pain? _______________________________________________

If you did not have an injury, when did the pain start? _________________________

What are your primary sports and/or activities? _______________________________

How would you describe your pain? ___________________________________________

Do any of the following increase your pain?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>Minimally</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping on affected shoulder:</td>
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<tr>
<td>Lifting your arm overhead:</td>
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<tr>
<td>Reaching out from your side:</td>
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<tr>
<td>Reaching behind your back:</td>
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<td>Throwing motion:</td>
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<tr>
<td>Participating in sports:</td>
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<tr>
<td>Work activities:</td>
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</tbody>
</table>

Is there anything else that increases your pain: _______________________________

Do any of the following decrease your pain?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>Minimally</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest:</td>
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<td></td>
<td></td>
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<tr>
<td>Ice:</td>
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<td>Heat:</td>
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<tr>
<td>Over the counter medicines (Tylenol/Advil)</td>
<td>Yes</td>
<td>Minimally</td>
<td>No</td>
</tr>
<tr>
<td>Prescription medications:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is there anything else that decreases your pain: ______________________________
____________________________________________________________________

Does the pain move down your arm or up to your neck? Yes No

Do you have shoulder pain at night? Yes No

Do you have any of the following symptoms?
- Clicking, popping, or grinding in your shoulder: Yes No
- Weakness of your shoulder: Yes No
- Weakness of your arm, elbow, or hand: Yes No
- Numbness or tingling in your arm or hand: Yes No
- Stiffness of your shoulder: Yes No
- Persistent or recurrent neck pain: Yes No

Are there any other symptoms regarding your shoulder that we should know about?
____________________________________________________________________

Have you had any previous surgery to your shoulder? Yes No
If yes, what type of surgery did you have and when did you have the surgery?
____________________________________________________________________

Have you had any previous treatment for your shoulder pain such as:
- Cortisone injections: Yes No
- Physical therapy: Yes No
- Chiropractic care: Yes No
- Acupuncture: Yes No

Any other previous treatment for your shoulder pain: ________________________
____________________________________________________________________

In general are your symptoms getting better, getting worse, or staying about the same?
____________________________________________________________________

Have you had any x-rays taken of your shoulder? Yes No
If yes: Date of x-ray: ____________________________________________
X-ray facility: ___________________________________________________

Have you had an MRI of your shoulder? Yes No
If yes: Date of MRI: _____________________________________________
MRI facility: ____________________________________________________