

Shoulder Pain Questionnaire

Which shoulder is bothering you? Left Right Both

Are you left handed or right handed: Left Right

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 type of work do you do? _____

What are your primary sports or activities? _____

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

Do you have shoulder pain at night? Yes No

Do any of the following increase your pain?

Lifting your arm overhead: Yes Minimally No

Reaching out from your side: Yes Minimally No

Reaching behind your back: Yes Minimally No

Throwing motion: Yes Minimally No

Participating in sports: Yes Minimally No

Work activities: Yes Minimally No

Is there anything else that increases your pain: _____

Do any of the following decrease your pain?

Rest: Yes Minimally No

Ice: Yes Minimally No

Heat: Yes Minimally No

Over the counter medicines (Tylenol/Advil) Yes Minimally No

Prescription medications: Yes Minimally No

Is there anything else that decreases your pain: _____

