Shoulder Pain

Onset, Duration and Frequency

• Are you left handed or right handed?
  ◼️ Left ◼️ Right ◼️ Both

• Which side of your body is affected?
  ◼️ Left ◼️ Right ◼️ Both

• If both, which side is more severe?
  ◼️ Left ◼️ Right ◼️ Varies ◼️ About the same

• About how long have you had your Shoulder Pain?
  (Type a number in the box and click one of the choices)
  Left: **Enter numeric value in box**
  [ ] ◼️ day(s) ◼️ week(s) ◼️ month(s) ◼️ year(s) ◼️ I don't know
  Right: **Enter numeric value in box**
  [ ] ◼️ day(s) ◼️ week(s) ◼️ month(s) ◼️ year(s) ◼️ I don't know

• Over what period of time did you notice the start of your Shoulder Pain?
  Left: ◼️ Did not notice ◼️ Suddenly ◼️ Over several hours ◼️ Over several days
  ◼️ Over several weeks ◼️ Over several months ◼️ Does not apply
  Right: ◼️ Did not notice ◼️ Suddenly ◼️ Over several hours ◼️ Over several days
  ◼️ Over several weeks ◼️ Over several months ◼️ Does not apply

• Is your Shoulder Pain the result of an injury?
  Left: ◼️ Yes ◼️ No     Right: ◼️ Yes ◼️ No
  • If your condition was the result of a sudden injury and you remember the exact date of the injury, please insert the date below.
    Mon Day Year
    Left: [ ] [ ] [ ] (mm/dd/yyyy)
    Right: [ ] [ ] [ ] (mm/dd/yyyy)

• If your condition was the result of an injury, please provide a short description of how the injury occurred.
  Left:
  [ ]
  Right:
• If your condition was the result of an injury, did you have any pain in this area before the injury?
  Left: ☐ Yes ☐ No  Right: ☐ Yes ☐ No

• Is your Shoulder Pain a result of your work?
  Left: ☐ Yes ☐ No  Right: ☐ Yes ☐ No

• In the past, have you had similar episodes?
  Left: ☐ Yes ☐ No  Right: ☐ Yes ☐ No

**Pain**

• How often do you have pain?
  Left: ☐ Not at all ☐ Intermittently ☐ Frequently ☐ Constantly
  Right: ☐ Not at all ☐ Intermittently ☐ Frequently ☐ Constantly

**Pain Location**

• Where do you feel your pain? (Check all that apply)
  L  R  Location of Pain
  ☐ ☐ Deep inside
  ☐ ☐ Top of the shoulder
  ☐ ☐ Front of the shoulder
  ☐ ☐ Back of the shoulder
  ☐ ☐ Upper arm
  ☐ ☐ Neck
  ☐ ☐ Shoulder blade area

**Pain Nature**

• Which of the following would you use to describe your pain? (Check all that apply)
  L  R  Nature of Pain
  ☐ ☐ Mild
  ☐ ☐ Moderate
  ☐ ☐ Severe
  ☐ ☐ Deep
  ☐ ☐ Stabbing
  ☐ ☐ Aching
  ☐ ☐ Sharp
  ☐ ☐ Dull
**Pain Scale**

- Please choose a number on the pain scale that best describes the amount of pain you feel with your Shoulder Pain. A "1" indicates mild pain and a "10" indicates severe pain.

Left:
- No pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Right:
- No pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

**Symptoms**

- Do you have any of the following symptoms? (Check all that apply)

  L  R  Complaint
  - Catching
  - Swelling
  - Stiffness
  - Weakness
  - Numbness in the arm
  - Tingling in the arm

- Have you ever had any problems in any of these joints? (Check all that apply)

  L  R  Joint
  - Shoulder
  - Elbow
  - Wrist / hand
  - Hip
  - Knee
  - Ankle
  - Foot

**Associated Problems**

- Have you ever had any of the following? (Check all that apply)

  - Diabetes
  - Thyroid disease
  - Arthritis
  - Neck problems
  - Previous shoulder injuries
  - Tendonitis
  - Tendon ruptures
**Functional Limitations**
• Does your problem cause you to have difficulty with any of the following? (Check all that apply)
  - [ ] Dressing
  - [ ] Reaching overhead
  - [ ] Lifting any weight
  - [ ] Washing hair
  - [ ] Throwing
  - [ ] Reaching back (such as reaching from the front seat to the back seat of your car)
  - [ ] Lifting the arm to the side (even without any weight)
  - [ ] Fastening a bra (women only)
  - [ ] Putting a wallet into your back pocket

**Previous Diagnostic Studies**
• Have you had any of the following tests for your problem? (Check all that apply)
  - [ ] Bone scan
  - [ ] Nerve study
  - [ ] X-rays of the shoulder
  - [ ] X-rays of the neck
  - [ ] Arthrogram of the shoulder
  - [ ] MRI of the shoulder
  - [ ] CAT scan of the shoulder

**Non-Operative Care for this Condition**
• Have you had any of the following treatments for your problem? (Check all that apply)
  - [ ] Pain medications
  - [ ] Aspirin
  - [ ] Anti inflammatory medications
  - [ ] Prednisone
  - [ ] Cortisone injections
  - [ ] Physical therapy
  - [ ] Acupuncture
  - [ ] Home exercises
  - [ ] Sling
  - [ ] Personal trainer
**Previous Surgical Procedures**

• Have you had any of the following surgical procedures? (Check all that apply)
  
  □ Arthroscopy of the shoulder
  □ Rotator cuff repair
  □ Operation for dislocating shoulder
  □ Operation for repair of shoulder fracture
  □ Removal of calcium deposits
  □ Shoulder replacement
  □ Neck surgery