SHOULDER QUESTIONAIRE

Name ________________________________ Age _____ Gender _____ Date_________
Occupation____

1. Medical Conditions: (check all that apply, past or current)
____None known
____Respiratory ____Asthma ____Emphysema ____ Other_______________
____Heart ____Coronary Artery Disease ___Heart attack/s ___Valve Problems
___Other____
____High Blood Pressure
____Stroke
____Stomach / GI ____Reflux ____Ulcer
____Kidney Disease
____Diabetes: ____Insulin ____ Oral Medication ____Diet
____Rheumatoid Arthritis ____Raynaud's ____Lupus ____Multiple Sclerosis
____Fibromyalgia ____Gout
____Endocrine Disorder ____Thyroid (___Hypo ____Hyper)
____Lyme Disease
____Blood Disorder ____Bleeding Problem ____Anemia
____Hepatitis ____A ____B ____C
____Cancer ____
____Tumor/s ____Benign ____Malignant
____Osteopenia / Osteoporosis
____Reflex Sympathetic Dystrophy (RSD) or **C**omplex **R**egional **P**ain **S**yndrome
____Neuropathy ___Neuritis
____Treatment for Pain Management
____Depression ____Alcoholism ____Drug Dependency
____Other____

2. Surgical History :
.*Type of operation* *Date* *Hospital*
____
____
____

3. Current medications & dosage: (including over-the-counter, herbal, etc.)
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

4. Allergies: (medication, food, latex, etc.)
____
____

(OVER)

5. Is this problem related to ___ sports, ___work, ___auto, ___other ___________

6. Which shoulder bothers you? Right____ Left____ Both____

7. Did you have a specific injury? Yes ____ No ____

8. When did the injury or problem first appear?
   Month ____ Day ____ Year ____

9. During what sport or activity did the injury/problem occur? _________________

10. Which of the following activities below are associated with pain:
    ____Carrying books or packages at your side
    ____Overhead work ____Throwing
    ____Swimming ____Swinging (racquet, bat, golf club, etc.)
    ____Push-ups ____Sleeping
    Other_______________________________

11. Which picture best illustrates how your injury occurred? Circle one.

12. What kind of shoulder problem are you experiencing?
    ____Pain ____Swelling ____Stiffness
    ____Clicking ____Instability (partial dislocation)

13. Was there a "snap" or "pop" at the time of injury?
    ____Yes ____No ____No injury involved

14. Have you ever had numbness in your hand or arm? ____Yes ____No

15. Does your arm ever go "dead" after throwing?
    ____Yes…at what point?____
    ____No
    ____Does not apply

16. Has your shoulder ever dislocated?
    ____Yes, once
    ____Yes, more than once… How many times?____
    ____Never

17. In reference to question #16, please describe the method of reduction (E.R. doctor, coach, etc.) and the amount of time that the shoulder was immobilized:
    ____
    ____
    ____
    ____does not apply

18. Who first saw you and evaluated your injury?
    When?_________________
    ____Emergency room physician
    ____Family physician
    ____Orthopaedic surgeon
    ____Coach or trainer
    Other______________________

19. What was the first diagnosis after your injury or problem?
    ____

20. Do you do upper body weight training on a regular basis? ____Yes ____No

21. Do you warm up before your sport? ____Yes…How long?______
    ____No
    ____Does not apply

22. Do you do flexibility exercises? ____Yes ____No

23. Has there been a recent change in your work, training intensity or technique?
    ____Yes ____No

24. Which is your dominant arm? Right____ Left____

25. What other treatments, if any, have you received for this problem?
    ____
    ____
    ____
    ____

(OVER)

26. If you have had any other shoulder problems in the past, please identify them:
____
____
____

27. What is the nature of your pain? (dull, sharp, burning, throbbing, aching)__________
____

28. Do you notice that your shoulder has any temperature changes? (hot, cold)______
____

29. Do you notice any skin color changes? If yes where? _________________________

30. Is light touch to skin painful? ____

31. Does ice application cause increased pain? (yes, no) __________________________

Please check the appropriate level of pain, weakness, and instability in both shoulders.

Pain:	**Right**	**Left**
1. Severe with daily activities	_____	_____
2. Moderate with daily activities	_____	_____
3. Slight with daily activities	_____	_____
4. With light recreational sports	_____	_____
5. With hard throwing, hitting, lifting or heavy labor	_____	_____
6. No pain with any activity	_____	_____

Weakness:	**Right**	**Left**
1. Severe impairment of daily activities	_____	_____
2. Moderate impairment of daily activities	_____	_____
3. Slight impairment of daily activities	_____	_____
4. Noticed in light recreational sports or light work	_____	_____
5. Noticed during maximum exertion only	_____	_____
6. No weakness	_____	_____

Instability: (complete or partial)	**Right**	**Left**
1. Occurs often with daily activities	_____	_____
2. Occurs occasionally with daily activities	_____	_____
3. Occurs seldom with daily activities	_____	_____
4. Present in light recreational sports or light work	_____	_____
5. Present only during maximum exertion	_____	_____
6. No instability	_____	_____