UTAH ORTHOPAEDIC SPECIALISTS

Shoulder Questionnaire

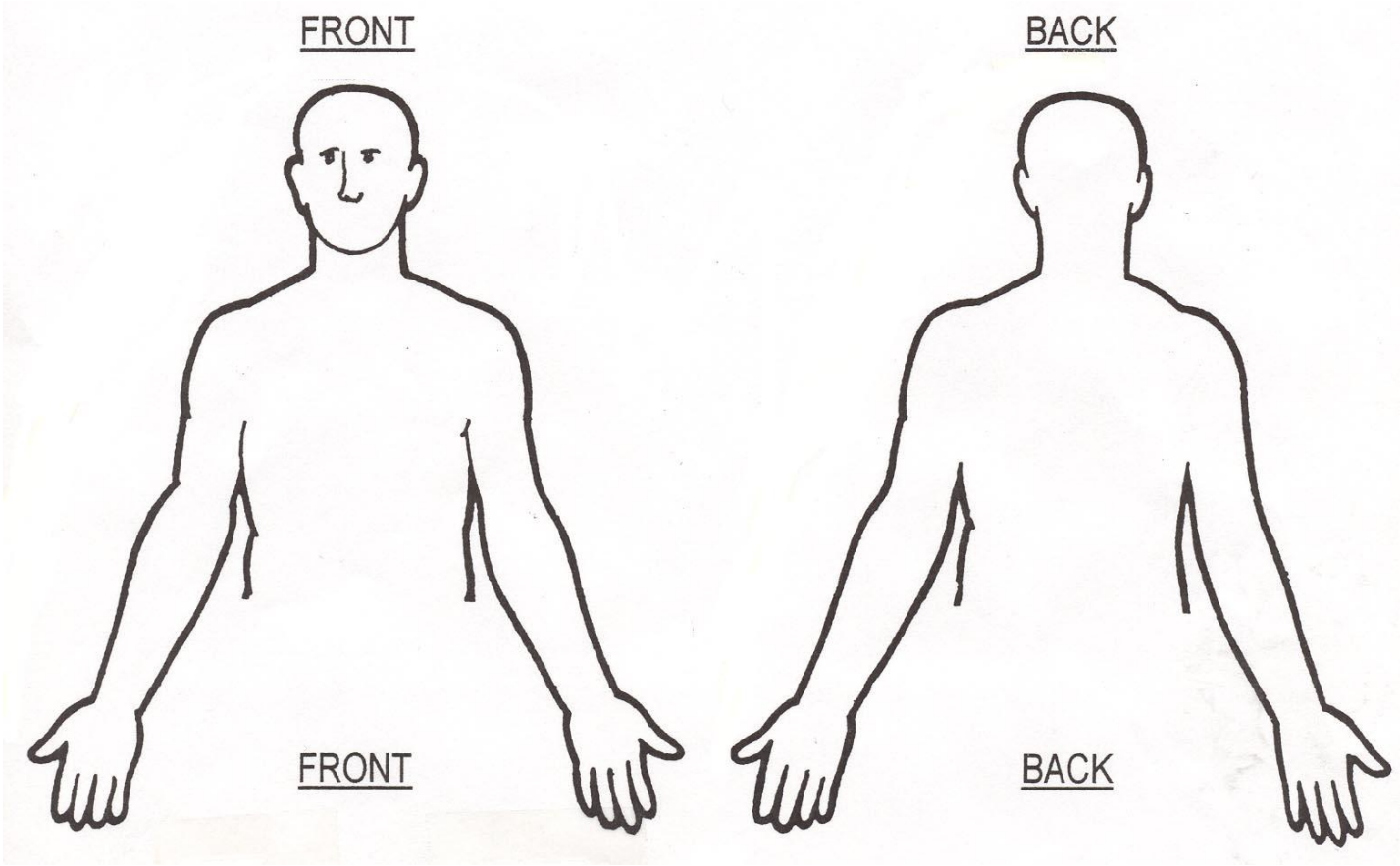
Name:_____ Age:_____ Occupation:_____ Date:_____

1. What happened to your shoulder? _____
2. Which shoulder? L or R
3. When did it happen? Date: _____
4. How long have you had pain? Years: _____ Months:_____ Weeks:_____
5. What activities cause pain in your shoulders? _____
6. Does your shoulder slip out of joint ("dislocate") Yes or No

   If so, what activities cause your shoulder to dislocate? _____

   How many times has it dislocated in the past year? _____
7. Please draw the location of your pain on the body outlines using the following key:

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	= = =	o o o	x x x	/ / /



Right Left Left Right

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Name:_____

8. What treatment have you had in the past (include physical therapy)? _____
9. Are you (please circle) better, worse, or the same since your treatment began?_____
10. Do you have pain in your shoulder at night? Yes or No
11. Have you ever had any surgery done on your shoulder? Yes or No
12. Have you ever had a cortisone injection in your shoulder? Yes or No

    If so, how many times? _____

    When were the shots given? Date:_____
13. What athletic activities do you participate in? Please list: _____
14. Are you taking any pain medications? If so, please list: _____
15. How many pain pills do you take each day? _____
16. Are you ALLERGIC to any medications? If so, please list: _____
17. Who referred you to this office? _____
18. How bad is your pain today (mark line with an **X**)?

    _____

    No pain at all Pain as bad as it can be
19. Does your shoulder feel unstable (as if it were going to dislocate)? Yes or No
20. How unstable is your shoulder (mark line with an **X**)?

    _____

    Very Stable Very **Un**stable
21. Circle the number in the box that indicates your ability to do the following activities:

    0 = Unable to do; **1** = Very difficult; **2** = Somewhat difficult; **3** = Not difficult

	Left Shoulder	**Right Shoulder**
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your side	0 1 2 3	0 1 2 3
3. Wash your back/do up a bra	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work- list:	0 1 2 3	0 1 2 3
10. Do usual sport- list:	0 1 2 3	0 1 2 3