

SHOULDER PAIN EVALUATION FORM

Name: _____

Date: _____

Which shoulder? R L If injured, date of injury: _____ Occupation: _____

Is this injury due to an accident? Yes No **On the job?** Yes No **Motor vehicle?** Yes No

If not injured, date of onset of symptoms: _____ Duration of symptoms: _____

Have you ever had surgery on your shoulder? _____

Which is your dominant shoulder? Right Left

Do you take pain medication, such as aspirin or Tylenol? Yes No

Do you take narcotic pain medication? Yes No What kind? _____

How bad is your pain today? Least = 1 2 3 4 5 6 7 8 9 10 = Max

Please write a brief description of how your injury or symptoms happened: _____

How would you describe the **worst** pain you have had from your shoulder?

None Mild Moderate Severe Unbearable

How would you describe the pain you **usually** have from your shoulder?

None Mild Moderate Severe Unbearable

Have you had trouble dressing yourself because of your shoulder?

No trouble at all Little trouble Moderate trouble Extreme difficulty Impossible to do

Have you had trouble getting out of a car or using public transportation because of your shoulder?

No trouble at all Little trouble Moderate trouble Extreme difficulty Impossible to do

Have you been able to use a knife and fork at the same time?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

Could you do the household shopping on your own?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

Could you carry a tray containing a plate of food across the room?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

Could you brush/comb your hair with the affected arm?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

Could you hang up your clothes using the affected arm?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

Have you been able to wash and dry yourself under both arms?

Easily Little difficulty Moderate difficult Extreme difficulty No, impossible

How much has your pain from your shoulder interfered with your usual work (including housework?)

Not at all A little bit Moderately Greatly Totally

Have you been troubled by shoulder pain in bed at night?

No Only 1 or 2 nights Some nights Most nights Every night

SHOULDER INSTABILITY EVALUATION FORM

Name: _____ Which shoulder? R L Date: _____

1. During the last 6 months how many times has your shoulder slipped out of joint?
 Not at all in 6 months
 1 or 2 times in 6 months
 1 or 2 times per month
 1 or 2 times per week
 More often than 1 or 2 times per week
2. During the last 3 months have you had any trouble (or worry) with putting on a T-shirt or pullover because of your shoulder?
 No trouble/No worries
 Slight trouble or worry
 Moderate trouble or worry
 Extreme difficulty
 Impossible to do
3. During the past 3 months how would you describe the worst pain your have had from your shoulder?
 None
 Mild aches
 Moderate
 Severe
 Unbearable
4. During the last 3 months how much has your shoulder interfered with your usual work?
 Not at all
 A little bit
 Moderately
 Greatly
 Totally
5. During the last 3 months have you avoided activity because you worried that your shoulder might slip out of joint?
 Not at all
 Very occasionally
 Some days
 Most days or more than 1 activity
 Every day, or many activities
6. During the last 3 months has the problem with your shoulder prevented you from doing things that are important to you?
 Not at all
 Very occasionally
 Some days
 Most days or more than 1 activity
 Every day, or many activities
7. During the last 3 months how much has the problem with your shoulder interfered with your social life, including sexual activity if applicable?
 Not at all
 Occasionally
 Some days
 Most days
 Every day
8. During the last 4 weeks, how much has the problem with your shoulder interfered with your sporting activities or hobbies?
 Not at all
 A little/occasionally
 Some of the time
 Most of the time
 All of the time
9. During the last 4 weeks how often has your shoulder been on your mind? How much have you thought about it?
 Never, only if someone asks
 Occasionally
 Some days
 Most days
 Every day
10. During the last 4 weeks how much has the problem with your shoulder interfered with your ability or willingness to lift heavy objects?
 Never, only if someone asks
 Occasionally
 Some days
 Most days
 Every day
11. During the last 4 weeks how would you describe the pain you usually had from your shoulder?
 None
 Very mild
 Mild
 Moderate
 Severe
12. During the last 4 weeks have you avoided lying in certain positions in bed because of your shoulder?
 No
 Only 1 night
 Some nights
 Most nights
 Every night