

PATIENT SHOULDER QUESTIONNAIRE

Vail•Summit
Orthopaedics



BP _____ / _____	Pulse _____	Temp _____
Resp _____		

Name _____ Age: _____

Today's Date: _____ Chart # _____ Sex: Male Female

*Problem With: Right Left Both – Which worse Right Left

I am : Right handed Left handed Ambidextrous

Work History:

Occupation: _____ Is Problem **Work Related**? Yes No If work injury, Date: _____

Are you presently working?

Yes Are you presently on modified duty? Yes No

No Unemployed, since _____ Off work, since _____ Last day worked? _____

If you are **not** working, is it due to your shoulder problem? Yes No

OR is it because you are Retired A Student A Homemaker Disabled Other

Is this problem related to a motor vehicle accident? Yes Date: _____ No

Is there an attorney involved with your worker compensation or auto accident claim? Yes No

Attorney: _____

*I am having problems with: (Mark all that apply)

<input type="checkbox"/> Pain at rest	<input type="checkbox"/> Pain with use of arm	<input type="checkbox"/> Instability (Shoulder pops out)
<input type="checkbox"/> Stiffness (Loss of motion)	<input type="checkbox"/> Weakness	<input type="checkbox"/> Grinding / Popping
<input type="checkbox"/> Catching / Locking	<input type="checkbox"/> Loss of work	<input type="checkbox"/> Loss of activity / sport
<input type="checkbox"/> Swelling		

Other Problems That Apply:

Neck Back Arthritis Nerve Problems Heart Lung Circulation Other

Do you have...

Neck Pain Trigger Points Upper Back Pain Trapezius Pain Radiation of Pain

Where does pain radiate? _____

The Problem is getting Better Worse No better / No worse .

Onset of the Problem:

Gradually, since _____ Describe: _____

Suddenly but without injury, on _____ Describe: _____

Injury, on _____ Occurred while: Throwing Lifting Falling Skiing Snowboarding
 Other Sport _____ Other _____ Don't know how I got this problem

Describe Injury: _____

Prior Treatment For This Problem:

Yes No If yes, Treated by: ER Family MD Orthopedic MD PT Chiropractor Self

If previously treated, what was the diagnosis? _____ Physician _____

Type of Prior Treatment	How often?	Over how long?	Help	Hurt	No Effect	Comments?
Physical Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-inflammatories			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Advil <input type="checkbox"/> Alleve <input type="checkbox"/> Rx
Cortisone Injections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many total? _____
Rest			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropractic			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Massage Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acupuncture			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Have you had other problems with your shoulders in the past? Yes No If yes, please describe: _____

Previous Shoulder Surgery: Yes No If yes, please complete lines below for each surgery:

Month/Day/Year	Doctor's Name:	Type:	Results:
1) _____	_____	_____	_____
2) _____	_____	_____	_____

Previous X-Rays: Yes No If yes, please list the date, location and results below (if you know):

Month/Day/Year	Location (Hospital/ER/Office/Doctor/City)	Results:
1) _____	_____	_____
2) _____	_____	_____

Previous MRI / Arthrogram / Ultrasound / CAT Scan: Yes No If yes, please complete lines below (if you know):

Month/Day/Year	Location (Hospital/ER/Office/Doctor/City)	Type of Study (MRI etc.)	Results:
1) _____	_____	_____	_____
2) _____	_____	_____	_____

PAIN:

If you are not experiencing pain, then skip this section and go to "Instability" top of page 4:

***Quality of Pain:**

<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aching	<input type="checkbox"/> Burning

***Location of Pain:**

<input type="checkbox"/> Cannot locate exact spot	<input type="checkbox"/> Front	<input type="checkbox"/> Side
<input type="checkbox"/> Back	<input type="checkbox"/> Arm pit	<input type="checkbox"/> Top side
<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand	<input type="checkbox"/> AC joint
		<input type="checkbox"/> Other _____

INSTABILITY:

(If your shoulder does not “go out of place”, skip this section).

My Shoulder Goes Out:

<input type="checkbox"/> At the time of the original injury	<input type="checkbox"/> Regularly	<input type="checkbox"/> With major injury or stress
<input type="checkbox"/> With simple movements	<input type="checkbox"/> Partially then goes back in	<input type="checkbox"/> Never but feels like it might

Complete dislocations occur how often? _____ Total number of dislocations _____

Date first dislocation: _____ Date last dislocation: _____

Does your shoulder hurt when its not out of place? No Occasionally Frequently Mild Moderate

Are you able to intentionally slip your shoulder out of place? Yes No

Have you required help to put shoulder back in? Yes No Explain: _____

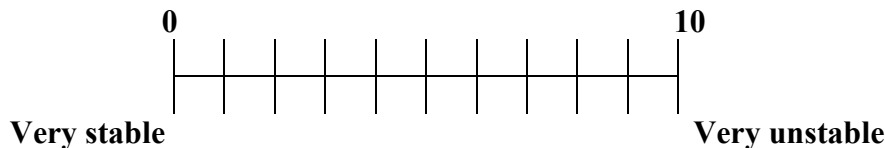
Have you been able to put the shoulder back in by yourself? Yes No Explain: _____

The shoulder goes back in: Easily With moderate difficulty With great difficulty .

Describe shoulder position when it goes out: _____

Where does the shoulder go out? Front Back Armpit Not sure

How unstable is your shoulder (mark line)?



PLEASE SIGN: The information is accurate to the best of my knowledge. _____

For Office use only	Complete _____ Date ____ / ____ / ____
	MD/PA _____ Date: _____ Clinician _____ Date: _____