SHOULDER PAIN EVALUATION FORM

Last Name: ______________________________ First 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 try 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

Last Name: ______________ First 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 life 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 might
    - ☐ Some nights
    - ☐ Most nights
    - ☐ Every night