ORTHOPEDIC ASSOCIATES of Northern California

Todays Date:_____

SHOULDER QUESTIONAIRE

NAME:_____ **REFERRED BY?**_____

Which shoulder are we seeing you for today (please circle)? Right Left Both
Occupation:_____ Are you currently working: _____
Do you feel your injury is work related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

How was your shoulder injured (Include date, if any, and how long you have had a problem)?

_____

_____

Dominant Hand: Left Right

PAIN

Where exactly is most of your pain _____
Frequency of pain: Constant Intermittent
Pain Scale (circle one): 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Character of pain: Sharp Dull Nagging Burning Throbbing
Aggravating activities (please circle):
Reaching forward/overhead Throwing Lifting Over the shoulder work
Increased at night Does pain wake you up at night?
Other:_____

Do you have pain with head/neck movements? Yes No
Do you have a history of neck/back problems? Yes No
Numbness in your arm/fingers? Yes No
Weakness in your affected arm? Yes No
Giving out/dislocations? Yes No
Locking, Catching, Clicking (please circle)? Yes No
Swelling? Yes No
Loss of Motion? Yes No
Prior shoulder problems? Yes No
Prior shoulder surgery? Yes No
Does the pain radiate anywhere (ie: up your neck or down your arm? Yes No
Where?_____

Treatment Received for current condition
Medications _____
Injections _____
Physical Therapy (How many sessions) _____
Surgery _____
Other Physicians _____