

Shoulder History Form

Name: _____ Date of Birth: _____

Which shoulder hurts? **Right** **Left** **Both** Hand dominance? **R** **L** **Ambidextrous**

Date of injury or onset of symptoms? _____ Worker's comp injury? **No** **Yes**

Was the current onset acute or gradual? _____ Motor vehicle accident? **No** **Yes**

Do you have neck pain? **No** **Yes** _____

Have you had a prior injury? **No** **Yes** _____

Have you seen anybody else? **No** **Who?** _____

Describe your injury:

My main problem is: **Pain** **Weakness** **Stiffness** **Locking** **Instability**

(instability means feelings of bones coming out of joint or shifting on each other)

My shoulder catches (doesn't move freely for several seconds) **No** **Yes**

At the time of injury: did you feel or hear a pop? **No** **Yes**

Did you have swelling? **No** **Yes**

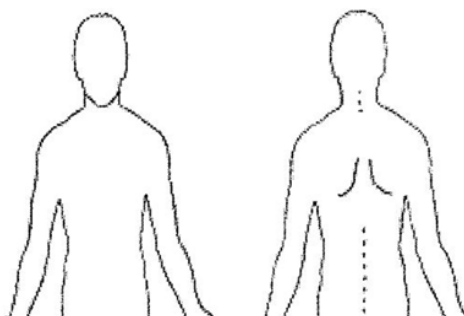
Describe your pain:

Rate your pain on a scale of 1 to 10:

1 2 3 4 5 6 7 8 9 10
Minimal Worst ever

Locate your pain:

Ache xxxx
Burning oooo
Sharp /////
Numbness ****
Other □□□□



What makes your pain better?

What makes your pain worse?

Do you have trouble with your activities of daily living?
(putting on shoes/socks, cooking, laundry, bathing, etc.) **No** **Yes**
Explain:

Do you have difficulties at work? **No** **Yes**
Explain:

Are overhead activities worse? **No** **Yes**

Have you noticed weakness? **No** **Yes**

Do you have any numbness or tingling? **No** **Where** _____

What are the hobbies/sports that you participate in? _____

Does your pain limit your participation in these? **No** **Yes** _____

Do you have pain at rest? **No** **Yes**

Do you have pain at night? **No** **Yes**

Have you taken any medication for the pain? **No** **Yes** _____

Have you tried anything else for the pain? **No** **Yes** **Ice** **Brace** **Other** _____

Have you had steroid injections in your shoulder? **No** **Yes** **#** _____

Patient Signature: _____ **Date:** _____