Michigan Orthopedic Center

TELL ME ABOUT YOUR SHOULDER PROBLEMS:

Patient Name: _____ Date: _____

E-mail: _____

Affected Side: L or R (circle one) **Dominant arm: L or R (circle one)**

Thank You for answering this brief questionnaire by marking the appropriate answers

1. **How would you characterize the onset of your shoulder pain?**
   R ☐ L ☐ Sudden
   R ☐ L ☐ Gradual
   R ☐ L ☐ Unknown
   R ☐ L ☐ Other: _____

2. **What antecedent events brought on your shoulder pain?**
   R ☐ L ☐ Unknown
   R ☐ L ☐ Trauma
   R ☐ Other: _____
   L ☐ Other: _____

3. **What has the pattern of your shoulder pain been?**
   R ☐ L ☐ Persistent
   R ☐ L ☐ Intermittent
   R ☐ L ☐ Increasing
   R ☐ L ☐ Decreasing
   R ☐ L ☐ Unchanging

4. **How long has your shoulder hurt you?**
   R ____ years
   ____ months
   _____ exact date of onset (if known)
   L ____ years
   ____ months
   _____ exact date of onset (if known)

5. **Where exactly is your pain located?**
   R ☐ L ☐ Front of shoulder
   R ☐ L ☐ Back of shoulder
   R ☐ L ☐ Entire shoulder
   R ☐ L ☐ Between shoulder and elbow
   R ☐ L ☐ Elbow
   R ☐ L ☐ Between elbow and wrist
   R ☐ L ☐ Neck
   R ☐ Other: _____
   L ☐ Other: _____

6. **Rate your average shoulder pain over the last week.**
   R ☐ none=0 1 2 3 4 5 6 7 8 9 10=severe

   L ☐ none=0 1 2 3 4 5 6 7 8 9 10=severe

7. **Rate your shoulder pain 6 months ago.**
   R ☐ none=0 1 2 3 4 5 6 7 8 9 10=severe

   L ☐ none=0 1 2 3 4 5 6 7 8 9 10=severe

8. **What best describes your shoulder pain?**
   R ☐ L ☐ Aching
   R ☐ L ☐ Sharp
   R ☐ L ☐ Throbbing
   R ☐ L ☐ Burning
   R ☐ L ☐ Tingling
   R ☐ Other:_____
   L ☐ Other:_____

9. **What activities do you have difficulty doing as a result of your shoulder pain?**
   R ☐ L ☐ Putting on Coat
   R ☐ L ☐ Sleeping on Painful Area
   R ☐ L ☐ Washing Back
   R ☐ L ☐ Doing Up Bra in Back
   R ☐ L ☐ Managing Toileting
   R ☐ L ☐ Combing Hair
   R ☐ L ☐ Reaching a High Shelf
   R ☐ L ☐ Lifting 10lbs Above Shoulder
   R ☐ L ☐ Throwing a Ball Overhead
   R ☐ L ☐ Doing Usual Work
   R ☐ L ☐ Doing Usual Sports
   R ☐ Other: _____
   L ☐ Other: _____

10. **What relieves your shoulder pain?**
    R ☐ L ☐ Nothing
    R ☐ L ☐ Rest
    R ☐ L ☐ Heat
    R ☐ L ☐ Ice
    R ☐ L ☐ Medication
    R ☐ L ☐ Exercise
    R ☐ L ☐ Modification of activity
    R ☐ L ☐ Topical Ointments (Bengay etc. . .)
    R ☐ Other: _____
    L ☐ Other: _____

11. What are the associated features of your shoulder pain?

R ☐ L ☐ Stiffness
R ☐ L ☐ Grinding
R ☐ L ☐ Catching
R ☐ L ☐ Locking
R ☐ L ☐ Instability
R ☐ L ☐ Weakness
R ☐ L ☐ Numbness
R ☐ L ☐ Tingling
R ☐ L ☐ Decreased range of motion
R ☐ L ☐ Neck pain
R ☐ Other: _____
L ☐ Other: _____

12. What previous diagnostic tests have you had?

R ☐ L ☐ None
R ☐ L ☐ Plain X-rays
R ☐ L ☐ Arthrogram
R ☐ L ☐ MRI
R ☐ L ☐ CT
R ☐ L ☐ Bone Scan
R ☐ Other: _____
L ☐ Other: _____

13. Note if any of the following have evaluated or treated your neck or upper extremities.

R ☐ L ☐ Orthopedic surgeon
R ☐ L ☐ Neurosurgeon
R ☐ L ☐ Neurologist
R ☐ L ☐ Rheumatologist
R ☐ L ☐ Chiropractor
R ☐ L ☐ Pain management
R ☐ Other:_____
L ☐ Other:_____

14. Have you ever had neck surgery?

☐ Yes ☐ No

15. Have you had physical therapy for your shoulder?

Yes ☐ **(if yes, when?)** No ☐
R_____
L_____

16. Have you had any previous surgeries on your shoulder?

☐ Yes ☐ No
(if yes, what surgery and when?)
R_____
_____
L_____
_____

17. What medications have you taken? (mark a P for those used in the PAST) (mark a C for those used CURRENTLY)

___ None
___ Tylenol
___ Aspirin
___ Topical Rub/Pain Patch
___ Ibuprofen/Motrin/Advil
___ Aleve/Naprosyn/Naproxyn
___ Clinoril/Sulindac
___ Celebrex
___ Mobic/Meloxicam
___ Other NSAID: _____
___ Cortisone injection ☐ R ☐ L
___ Ultram/Tramadol/Ultracet
___ Narcotic: _____
___ Glucosamine / Chondroitin
___ Other: _____

18. How would you characterize your shoulder problem?

R ☐ L ☐ An inconvenience
R ☐ L ☐ More than an inconvenience
R ☐ L ☐ Disabling