Shoulder Questionnaire

ALTA ORTHOPAEDICS

Name:_____ **Date:**_____

Area of problem: **Right** **Left** **Both**

My major complaint is: (Please circle) **pain / weakness / loss of motion / catching, popping or clicking**

How did this problem begin? (Please circle) **gradually / suddenly / at work / vehicle accident / sports**

Do you feel your symptoms: (Please circle) **are improved / are more severe / are the same**

Does the affected shoulder hurt: (Please circle) **infrequently / when active / constantly**
Is the pain: (Please circle) **sharp / dull / aching**

What makes the pain worse? (Please circle below)
Overhead reaching / reaching behind the back / daily activities / work activities / lifting / exercise

Other:_____

The pain is relieved by: (Please circle) **nothing / rest / heat / cold / activity / medicine, what kind?**_____

Does the pain wake you at night? (Please circle) **yes / no**

Does lying on your side cause pain? (Please circle) **yes / no**

Does your shoulder feel loose, slip in/out of socket, or dislocate? (Please circle below)
Infrequently / constantly / only after activity / only at time of injury

Do you have pain in your neck? (Please circle) **yes / no**

Does the pain travel down your arm into your fingers? (Please circle) **yes / no**
Which fingers? (Please circle) **thumb / index / long / ring / little**

Does turning your head side to side or looking up and down cause pain to travel into your shoulder or down your arm? (Please circle) **yes / no**

Do you have any numbness or tingling in your hand? (Please circle) **yes / no**

Does holding your arm overhead make the numbness or tingling: (Please circle below)
Better / worse / same

Do you exercise regularly? **Walk / run / weights / recreational or competitive sports / other:**_____

Have you had to modify your regular activities? **Work / sports / other:**_____