Shoulder Pain Questionnaire

Name_____

Which shoulder is bothering you? Left Right Both

Are your left handed or right handed? Left Right

What type of work do you do? _____

Did your shoulder pain start with a specific injury? Yes No

If yes: Date of injury: _____

Mechanism of injury: _____

Did you feel a pop or snap with the injury: Yes No

Is the injury work related: Yes No

If there was no injury, did the pain start with a particular activity (such as baseball, tennis, painting, etc.)? Yes No

If yes, what started the pain? _____

If you did not have an injury, when did the pain start? _____

What are your primary sports and/or activities? _____

How would you describe your pain? _____

Do any of the following increase your pain?

Sleeping on affected shoulder:	Yes	Minimally	No
Lifting your arm overhead:	Yes	Minimally	No
Reaching out from your side:	Yes	Minimally	No
Reaching behind your back:	Yes	Minimally	No
Throwing motion:	Yes	Minimally	No
Participating in sports:	Yes	Minimally	No
Work activities:	Yes	Minimally	No

Is there anything else that increases your pain: _____

_____

Do any of the following decrease your pain?

Rest:	Yes	Minimally	No
Ice:	Yes	Minimally	No
Heat:	Yes	Minimally	No
Over the counter medicines (Tylenol/Advil)	Yes	Minimally	No
Prescription medications:	Yes	Minimally	No

Is there anything else that decreases your pain: _____

_____

Does the pain move down your arm or up to your neck? Yes No

Do you have shoulder pain at night? Yes No

Do you have any of the following symptoms?

Clicking, popping, or grinding in your shoulder:	Yes	No
Weakness of your shoulder:	Yes	No
Weakness of your arm, elbow, or hand:	Yes	No
Numbness or tingling in your arm or hand:	Yes	No
Stiffness of your shoulder:	Yes	No
Persistent or recurrent neck pain:	Yes	No

Are there any other symptoms regarding your shoulder that we should know about?

_____

_____

Have you had any previous surgery to your shoulder? Yes No

If yes, what type of surgery did you have and when did you have the surgery?

_____

_____

Have you had any previous treatment for your shoulder pain such as:

Cortisone injections:	Yes	No
Physical therapy:	Yes	No
Chiropractic care:	Yes	No
Acupuncture:	Yes	No

Any other previous treatment for your shoulder pain: _____

_____

In general are your symptoms getting better, getting worse, or staying about the same?

_____

Have you had any x-rays taken of your shoulder? Yes No

If yes: Date of x-ray: _____

X-ray facility: _____

Have you had an MRI of your shoulder? Yes No

If yes: Date of MRI: _____

MRI facility: _____