

Initial Shoulder Evaluation Form

Name _____

Date ____/____/____

Shoulder(s) Injured: Right/Left/Both

Dominant Arm: Right/Left

Referring Physician _____

Date of onset or Injury _____

Description of Injury _____

Were you injured playing a sport? Y/N If yes, what sport? _____

Occupation: _____ Is this injury work related? Y/N

Have you had previous injuries to your shoulder? Y/N

If yes, please describe _____

What are your primary symptoms? (please circle all that apply)

Pain Weakness Feeling that the shoulder is slipping out of place

How often do you have your symptoms? (please circle all that apply)

All the time Occasionally Rarely Only with certain motions
(continuous) Please describe _____

If you have pain, would you describe it as: Sharp Dull Ache

Do you have pain at night? Y/N Do you have any neck pain? Y/N

Do you have any numbness or tingling in your hands or fingers? Y/N

Previous treatment (please circle all that apply)

Physical therapy Y/N Approximate # of visits _____

Injections Y/N # of injections _____

Medications Y/N If yes, list all medications for shoulder only

Do you have anything else that you would like to share about your shoulder?

Please mark your answer with an X and please answer all questions

In general would you say that your health is:

Excellent

Very good

Good

Fair

Poor

Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago

Somewhat worse than one year ago

Somewhat better now than one year ago

Much worse than one year ago

About the same as one year ago

These questions are about how you feel and how things have been with you during the past four weeks. For each question please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past four weeks.....

	All of the time	Most of the time	A bit of the time	Some of the time	A little of the time	None of the time
a. did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All the time
 Most of the time
 Some of the time
 A little of the time
 None of the time

How true or false is each of the following statements?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. my health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Where is the pain in your shoulder?

Top
 Bottom
 Front
 Back
 Shoulder blade

Pain: Please mark the appropriate response to the following question concerning your pain. To what degree do you experience pain?

	Always and unbearable	Always but bearable	After or during light activities	Only during heavy or certain activities	None
During the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

	Limited a lot	Limited a little	Not limited
a. vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. lifting or carrying groceries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. climbing several flights of stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. climbing one flight of stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. bending, kneeling or stooping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. walking more than a mile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. walking several blocks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. walking one block.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. bathing or dressing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past four weeks, have you had any of the following problems while working or doing other activities as a result of your physical health?

	YES	NO
a. cut down on the amount of time you spend on work or other activities.....	<input type="checkbox"/>	<input type="checkbox"/>
b. accomplished less than you would like.....	<input type="checkbox"/>	<input type="checkbox"/>
c. were limited in the kind of work or other activities.....	<input type="checkbox"/>	<input type="checkbox"/>
d. had difficulty performing the work or other activities.....	<input type="checkbox"/>	<input type="checkbox"/>

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
a. cut down on the amount of time you spent on work or other activities.....	<input type="checkbox"/>	<input type="checkbox"/>
b. accomplished less than you would like.....	<input type="checkbox"/>	<input type="checkbox"/>
c. did not work or other activities as carefully as usual.....	<input type="checkbox"/>	<input type="checkbox"/>

During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with your family, friends, neighbors or groups?

Not at all
 Slightly
 Moderately
 Quite a bit
 Extremely

How much bodily pain have you had during the past four weeks?

None
 Very mild
 Mild
 Moderate
 Severe
 Very severe

During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and all house work)?

Not at all
 Slightly
 Moderately
 Quite a bit
 Extremely

