

SHOULDER

As part of Wellington Orthopaedic and Sports Medicine's continuing commitment to excellence in patient care, we would appreciate it if you could complete this form and bring it to your office visit that you have scheduled with Dr. Heidt, Jr. In doing so you will help us to insure the high quality services that we have to offer. Please check the box next to the best answer for every question. Thank you for your cooperation.

Name _____
DOB _____

Date _____
Shoulder R L

1. Please describe the nature of your shoulder injury.
 - Acute (single event within the last 3 weeks)
 - Chronic (multiple recurrent injuries over a period of time)

2. Please describe the shoulder pain you experience today.
 - Present always and unbearable; strong medication frequently
 - Present always, but bearable; strong medication occasionally
 - None or little at rest, present during light activities only; aspirin or anti-inflammatories occasionally
 - Present during heavy or particular heavy activities only; aspirin or anti-inflammatories occasionally
 - Occasional and slight
 - None

3. Please describe the function of your shoulder today.
 - Unable to use limb
 - Only light activities possible
 - Able to do light housework or most activities of daily living
 - Most housework, shopping, and driving possible; able to do hair and dress and undress, including fastening bra
 - Slight restriction only, able to work above shoulder level
 - Normal activities

4. Occurred during: No sport

<input type="checkbox"/> Football	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Wrestling	<input type="checkbox"/> Rowing
<input type="checkbox"/> Basketball	<input type="checkbox"/> Track & Field	<input type="checkbox"/> Skiing	<input type="checkbox"/> Tennis
<input type="checkbox"/> Soccer	<input type="checkbox"/> Base/Softball	<input type="checkbox"/> Swimming	<input type="checkbox"/> Other sport

