

Shoulder Questionnaire



Name: _____ Date: _____ Height: _____ Weight: _____ Side: R L

How bad is your pain today? (mark an X on the line)

No pain at all 0 10 Pain as bad as can be

How is your function today? (mark an X on the line)

Full use of arm 0 10 Cannot use arm

Check the appropriate answer	YES	NO	Pain (check one answer)
Is your shoulder comfortable with your arm at rest by your side?			<input type="checkbox"/> Present all the time and unbearable; strong medication frequently
Does your shoulder allow you to sleep comfortably?			<input type="checkbox"/> Present all the time but bearable; strong medication occasionally
Can you reach the small of your back to tuck in your shirt?			<input type="checkbox"/> None/little at rest; pain on light activity; anti-inflammatory medications used frequently
Can you place your hand behind your head?			<input type="checkbox"/> Present during heavy or particular activities only; anti-inflammatory meds used occasionally
Can you place a coin on a shelf?			<input type="checkbox"/> Occasional and slight
Can you lift 1 lb. (a full pint container) to your shoulder level?			<input type="checkbox"/> None. I have no pain.
Can you lift 8 lbs. (a full gallon) to your shoulder level?			
Can you carry 20 lbs. (a bag of potatoes) at your side?			Function (check one answer)
Do you think you can toss a softball underhand 10 yards?			<input type="checkbox"/> Unable to use your limb
Do you think you can toss a softball overhand 20 yards?			<input type="checkbox"/> Only light activities possible
Can you wash the back of your opposite shoulder?			<input type="checkbox"/> Able to do light housework or most activities of daily living
Will your shoulder allow you to work your full time job?			<input type="checkbox"/> Most housework, shopping, and driving possible, able to do hair and to dress and undress, including fastening bra
Satisfaction			<input type="checkbox"/> Slight restriction only; able to work above shoulder level
<input type="checkbox"/> I am satisfied (better)			<input type="checkbox"/> Able to do normal activities
<input type="checkbox"/> I am not satisfied (worse)			

Check the box that indicates your ability to do the following activities:								
Activity	Right Arm				Left Arm			
	Unable to do	Very difficult	Somewhat difficult	Not difficult	Unable to do	Very difficult	Somewhat difficult	Not difficult
Put on a coat								
Sleep on your painful/affected side								
Wash back/fasten bra in back								
Manage toileting								
Comb hair								
Reach a high shelf								
Lift 10 lbs above shoulder								
Throw a ball overhand								
Do usual work (list):								
Do usual sport (list):								

Visit	Affected side R L Hand Dom R L A Duration History Weightbearing Status: WB Non WB	<input type="checkbox"/> Night pain	Inspection R/L	Tenderness
<input type="checkbox"/> Preoperative		<input type="checkbox"/> Arm pain	<input type="checkbox"/> Symmetric	<input type="checkbox"/> Subacromial
<input type="checkbox"/> 3 month		<input type="checkbox"/> Difficulty using arm at shoulder level overhead	<input type="checkbox"/> SS Atrophy	<input type="checkbox"/> Biceps
<input type="checkbox"/> 6 month		<input type="checkbox"/> Limited motion	<input type="checkbox"/> IS Atrophy	<input type="checkbox"/> Acromial
<input type="checkbox"/> 1 year		<input type="checkbox"/> Deep ache	<input type="checkbox"/> Other	<input type="checkbox"/> Anterior
<input type="checkbox"/> 2 year		<input type="checkbox"/> Pain reaching across chest	Cervical Spine	<input type="checkbox"/> Posterior
<input type="checkbox"/> 5 year		<input type="checkbox"/> Pain reaching behind back	<input type="checkbox"/> Full ROM	<input type="checkbox"/> AC joint
Procedure		<input type="checkbox"/> Neck pain	<input type="checkbox"/> Limited ROM	<input type="checkbox"/> Paraspinous
<input type="checkbox"/> TSA		<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Spurlings +	<input type="checkbox"/> Trapezial
<input type="checkbox"/> RSA				
<input type="checkbox"/> Cuff				
<input type="checkbox"/>				

ROM	Inv R/L	Noninv	PROM Inv
AFE			
Abd			
ER			
IR			
@90 ER			
@90 IR			
Assisted FE			

FF:		SS:		IS/ER:		TM:	
Inv:	NI:	Inv:	NI:	Inv:	NI:	Inv:	NI:
5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1
0	0	0	0	0	0	0	0

Special Tests:		Complications:		Diagnosis:	
Neer: (+) (-)	Belly Press: (+) (-)	<input type="checkbox"/> Wound		1.	
Hawkins: (+) (-)	Bear Hug: (+) (-)			2.	
Painful Arc: (+) (-)	Lift Off: (+) (-)	<input type="checkbox"/> Antibiotics		3.	
Pain w SS: (+) (-)	Apprehension: (+) (-)			4.	
Cross Arm: (+) (-)	Relocation: (+) (-)	<input type="checkbox"/> Medical		5.	
Speed's: (+) (-)	Sulcus: (+) (-)				
Yergason's: (+) (-)	Anterior: 1 2 3 pain crep	<input type="checkbox"/> Shoulder		Plan:	
Popeye: (+) (-)	Posterior: 1 2 3 pain crep			<input type="checkbox"/> Injection	
O'Brien's: (+) (-)	Scap Dyskinesia: 1 2 3			<input type="checkbox"/> Physical Therapy	
Thumb/arm: (+) (-)				<input type="checkbox"/> Imaging	
Painful ER: (+) (-)				<input type="checkbox"/> Surgery	

Shoulder X-Ray: L R	X-Ray: Cervical Spine
<input type="checkbox"/> Negative with a: Type I II III acromion	<input type="checkbox"/> Negative
<input type="checkbox"/> Glenohumeral DJD: Mild Moderate Severe	<input type="checkbox"/> Loss of lordosis
<input type="checkbox"/> Rotator Cuff Arthropathy: Hamada Stage 1 2 3 4A 4B 5	<input type="checkbox"/> DJD
<input type="checkbox"/> AC Joint: Arthrosis Separation Grade 1 2 3	<input type="checkbox"/> C3-4 Loss of disc space height DJD
<input type="checkbox"/> S/P Shoulder Arthroplasty: Primary Reverse Revision	<input type="checkbox"/> C4-5 Loss of disc space height DJD
<input type="checkbox"/> Fracture	<input type="checkbox"/> C5-6 Loss of disc space height DJD
<input type="checkbox"/> Other	<input type="checkbox"/> C6-7 Loss of disc space height DJD