

Name: _____

DOB: _____



Date: _____

Shoulder Evaluation

Referring Physician: _____ Primary Care Physician: _____

Name a favorite hobby: _____

Which shoulder is affected?: Right Left Both Does your shoulder feel unstable? yes no

Describe how it happened _____

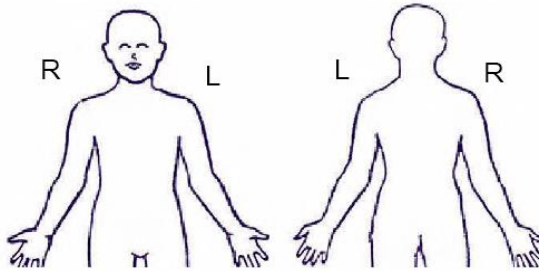
Describe where you were: _____

Personal Injury Fall Sports Injury Work related Chronic

Auto Accident-were you wearing a seatbelt? yes no

The date the symptoms began: _____

On this diagram mark where your pain is:



For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: _____

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS
INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN
OTHER _____

When is your pain worse? Mornings Evenings Always about the same

Is it worse after activity? yes no

What is your pain scale today: 0=no pain 10=worst pain	0 1 2 3 4 5 6 7 8 9 10 RIGHT	0 1 2 3 4 5 6 7 8 9 10 LEFT
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Have you ever experienced any injury to or symptoms involving this body part in the past? yes no

If so, please provide details: _____

What test have you had regarding this injury? NONE X-rays MRI CT scan Bone scan EMG/NCV
 Ultrasound Labs Other: _____

Have you had any treatment for this problem? NONE medication therapy splinting/brace injection
 surgery manipulation chiropractic treatment massage acupuncture pain specialist
 other: _____

- Was any of your treatment effective? Explain: _____

- Where did you receive treatment? _____

Name:

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Put an X in the box that indicates your ability to do the following activities

ASES SCORE	RIGHT				LEFT			
	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 side								
Wash back/clip bra								
Manage toileting								
Comb hair								
Reach a high shelf								
Lift 10 pounds above shoulder								
Throw a ball overhand								
Do usual work Example:								
Do usual sport Example:								

Please answer the following questions for BOTH your AFFECTED and UNAFFECTED shoulder. Please do not leave any questions unanswered. Please make notes on the back of this page as necessary.

DASH SCORE	RIGHT		LEFT	
Is your shoulder comfortable with your arm at rest by your side?	Yes	No	Yes	No
Does your shoulder allow you to sleep comfortably?	Yes	No	Yes	No
Can you reach the small of your back to tuck in your shirt with your hand?	Yes	No	Yes	No
Can you place your hand behind your head with the elbow straight out to the side?	Yes	No	Yes	No
Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	Yes	No	Yes	No
Can you lift 1 pound (one pint container) to the level of your shoulder without bending your elbow?	Yes	No	Yes	No
Can you lift 8 pounds (one gallon of milk) to the top of your head without bending your elbow?	Yes	No	Yes	No
Can you carry 20 pounds (a bag of potatoes) at your side?	Yes	No	Yes	No
Do you think you can toss a softball under-hand 10 yards?	Yes	No	Yes	No
Do you think you can toss a softball over-hand 20 yards?	Yes	No	Yes	No
Can you wash the back of the opposite shoulder?	Yes	No	Yes	No
Would your shoulder allow you to work full time at your regular job?	Yes	No	Yes	No

Patient Signature: _____