PRECLINIC SHOULDER PATIENT SURVEY

Patient Name:___________________________ DOB:_______________ Date:______________

Which shoulder will we be treating today? (please circle) RIGHT LEFT (if both, fill one form out for each shoulder)

Irritation with activity is caused by: (please answer YES or NO)

_____ Reaching – (please circle) – upward, backward, forward, outward, across _____ Carrying

_____ Lifting _____ Leaning _____ Climbing _____ Throwing _____ Tossing _____ Laying on shoulder

Sensations from shoulder: (check all that apply)

_____Weakness _____Limited Rotation _____ Stiffness

_____Tingling- (please circle) - upper arm, lower arm, hand

_____Numbness- (please circle) - upper arm, lower arm, hand

_____Swelling- (please circle) - upper arm, lower arm, hand

_____Pain- (please circle) - upper arm, lower arm, hand

What activity may cause the above sensations? ____

Does resting your arm in a sling or in a similar position relieve these symptoms? YES NO

Does resting your arm on your head relieve these symptoms? YES NO

Do you have difficulty sleeping? YES NO **If yes, does a certain position or use of a pillow help?** YES NO

Have you had any difficulty with the neck or upper back? YES NO

Do these symptoms improve, stay the same or worsen after initial morning activity? ________________

Has any medication improved these symptoms? (please list) ___________________________________

List any significant prior shoulder injuries, any history of trauma or surgeries: ____________________

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Check any of the following treatments or studies that have been performed for this condition:

_____CT Scan _____MRI _____Bone Scan _____X-ray _____Physical Therapy _____Injection

Patient Signature:____ **Date**:_________________