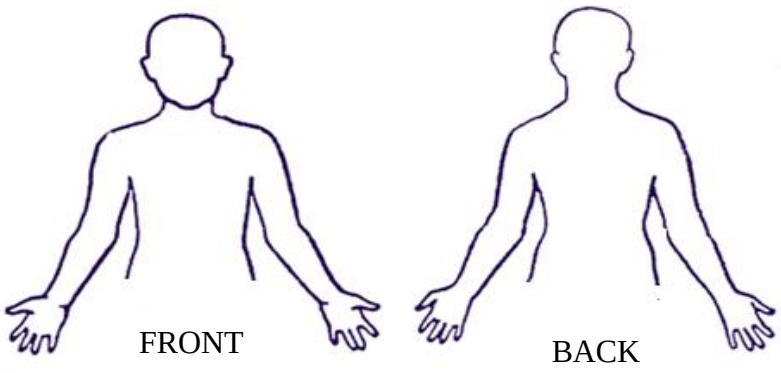
Name:
MR#:
Date:

(Medical Staff Only)
Patient Label

New Patient Questionnaire

(Place an X on the diagram for pain and an N for numbness)



Circle or write responses to the questions below:

Which hand do you write with? Right *or* Left

Which side are we treating? Right Left Both

How would you describe symptoms? Pain *or* Instability *or* Weakness

How long have you had symptoms? (fill)_____

Did the symptoms start with an injury? No *or* Yes
If yes, describe:_____

How often are the symptoms? Constant *or* Come and go

How Severe is the Pain MOST of the Time? (No Pain) 0 – 1- 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worse pain)

What makes the symptoms worse?

- ☐ Lifting
- ☐ Raising the arm above shoulder level
- ☐ Reaching behind
- ☐ Sleeping on the shoulder
- ☐ Other (list)_____

What treatments have you tried?

- ☐ Anti-inflammatories (Aleve, Ibuprofen, etc.)
- ☐ Prescription pain medication
- ☐ Physical therapy or strengthening
- ☐ Injections (list number)_____
- ☐ Surgery (list)_____
- ☐ Other (list)_____

ShouC1aE1bNP

For each activity, choose the answer that indicates your ability to do the following activities: (Mark with an X)

	Unable to do	Very Difficult to do	Somewhat Difficult	Not Difficult
1. Put on a coat				
2. Sleep on your painful or affected side				
3. Wash back/do up bra in back				
4. Manage toileting				
5. Comb hair				
6. Reach a high shelf				
7. Lift 10 lbs. above shoulder				
8. Throw a ball overhand				
9. Do usual work				
10. Do usual sport				

How would you rate your shoulder today as a percentage of normal? (0% to 100%)