UPPER EXTREMITY EVALUATION / NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC

GENERAL INFORMATION

Name: Birthdate: Visit Date:

Current problems are: Pain Weakness Stiffness Locking Instability Numbness Other

_____

Which shoulder Left Right Both
Onset of pain Sudden Gradual

Previous shoulder injury Yes No
Neck pain or radiation Yes No
Radiating pain past elbow Yes No
Night-time awakening Yes No
Ever dislocated shoulder Yes No If yes, how many dislocations _____

Previous shoulder surgery Yes No
Shoulder blade pain Yes No
Numbness or Tingling Yes No
Painful popping or catching Yes No

How often is the shoulder on your mind: Rarely Occasionally Sometimes Most times Constant

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0 = No pain / 1 = Mild, aware but not bothersome / 2 = Moderate, tolerate without medication / 3 = Moderate, requires medication
4-5 = More severe, begin to feel antisocial / 6 = Severe / 7-9 = Intensely severe / 10 = Most severe, may make you contemplate suicide

Circle your pain level using the guide below: **0 1 2 3 4 5 6 7 8 9 10**

TREATMENTS / MEDICATIONS / RADIOGRAPHIC STUDIES

Any **Physical Therapy** Yes No If YES, approximately how many visits, when, where:
Any **Injections** Yes No If YES, when and by whom and what was injected:
Any **Medications** for pain Yes No If YES, list medications and how often and how long used:
Any **Surgeries** Yes No If YES, when and by whom and what surgery:
Any **X-RAY** / **MRI** / **CT** done Yes No If YES, when, where, by whom:

SYMPTOMS *(circle all symptoms that apply to you)*

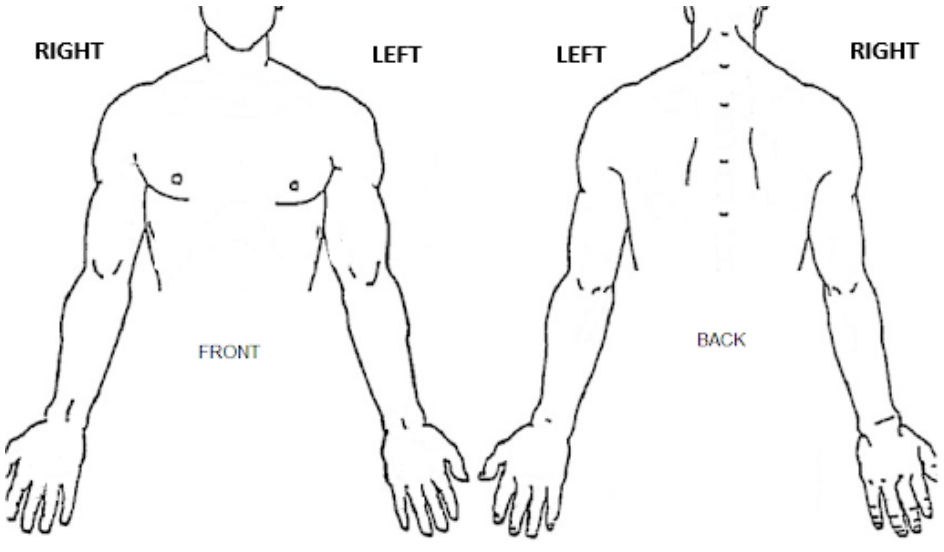
Throbbing / Shooting / Boring / Stabbing / Sharp / Pinching / Pressure / Gnawing / Cramping / Tugging / Pulling / Hot / Burning / Scalding / Searing / Tingling / Dull / Sore / Aching / Heavy / Agonizing / Tiring / Annoying / Miserable / Intense / Unbearable / Spreading / Radiating / Piercing / Tight / Numb / Tearing / Cold / Freezing / Nagging

FUNCTIONAL ABILITIES *(place the corresponding number next to the function)*

0 = Normal performance **1 = Bothersome to perform** **2 = Difficult to do** **3 = Avoid activity** **4 = Unable to do**

Use back pocket: ___ Perform toilet hygiene: ___ Wash under opposite arm: ___ Comb or brush hair: ___
Carry tray of food: ___ Dress/put on bra: ___ Sleep on shoulder:___ Hang up clothes with arm: ___
Interferes with work: ___ Interferes with sports: ___

KEY	
Show by filling in, marking and drawing on the front and back figures to the right where you are having any of the below symptoms:	
Aching &/or Pain	XXXX
Numbness &/or Tingling	ooooo
Pins &/or Needles	•••••••
Burning	//////
Spasms &/or Cramps	ΔΔΔΔΔ



Signature _____ Date _____ Rev. 02/05/2025