# SHOULDER 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 | Previous shoulder surgery | ☐ Yes | ☐ No |
| Neck pain or radiation | ☐ Yes | ☐ No | Shoulder blade pain | ☐ Yes | ☐ No |
| Radiating pain to forearm | ☐ Yes | ☐ No | Radiating pain below elbow | ☐ Yes | ☐ No |
| Night-time awakening | ☐ Yes | ☐ No | Painful popping or catching | ☐ Yes | ☐ No |
| Ever dislocated shoulder | ☐ Yes | ☐ No | If yes, how many dislocations _____ | | |

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

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

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

## 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)*

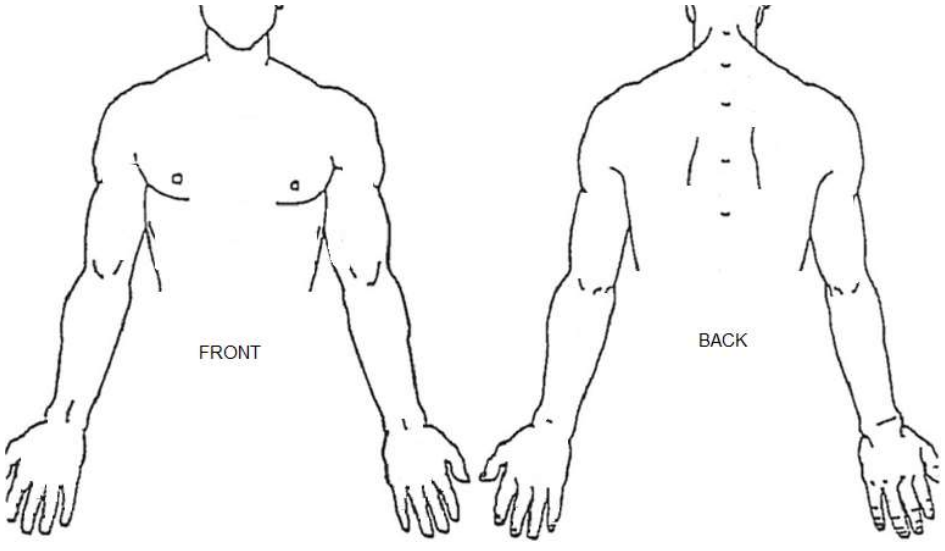
Throbbing / Shooting / Boring / Stabbing / Sharp / Pinching / Pressure / Gnawing / Cramping / Tugging / Pulling / Hot / Burning / Scalding / Searing / Tingling / Dull / Sore / Aching / Heavy / Agonizing / Tiring / Annoying / Miserable / Intense / Unbearable / Spreading / Radiating / Piercing / Tight / 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. 05/23/2018 ©