COMPREHENSIVE SHOULDER QUESTIONNAIRE

Name:____ Date:_____________

This questionnaire has been designed to assist in the evaluation of your shoulder problem. Please mark where indicated and fill in the blanks to the best of your ability. There will be time to discuss your symptoms in detail during the consultation.

1. Are you having any of these symptoms? ***(mark all that apply)***

Weakness Loss of Motion Catching, popping or clicking

2. Does your shoulder ever: ***(mark all that apply)***

Feel Loose? Slip in or out of socket? Get stuck or lock?

3. Do you have pain at night? .... Yes No

4. Does lying on your side cause pain?........................ Yes No

5. Which of these movements causes pain?

To shoulder height or above? ……………………… Yes No

Reaching behind your back? .... Yes No

Other____

6. What increases your symptoms?

Daily activities…………	Yes	No	Sports…………	Yes	No
Work activities………...	Yes	No	Exercise...........	Yes	No
Dressing……………….	Yes	No	Lifting..............	Yes	No

Other____

7. Has your problem caused you to stop or modify any of the above activities? .... Yes No

8. Does the pain travel down the arm? …………… Yes No

Does the pain travel to your fingers? …………... Yes No

Click or circle which finger Thumb Index Long Ring Little

9. **Do you have any numbness or tingling in your hand?** …………… Yes No

Does holding the arm overhead make it? …………………………. Better Worse

10. **Do you drop things?** …………………………….. Yes No

11. **Do you have any pain in your neck?** …………… Yes No

Does turning your head from side to side or looking up or down cause pain to travel into your shoulder or down your arm? ……………………………… Yes No

12. **Have you had this problem before?** ……………. Yes No

If yes, list treatment you have had including the number of shoulder injections.

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