

Name: \_\_\_\_\_

Date: MM / DD / YYYY

**IDENTIFYING THE PAIN**

Describe the injury/problem and past shoulder history

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Date of original injury: MM / DD / YYYY      Which Shoulder:  Right  Left      Dominant Hand:  Right  Left

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Have you felt:

Shift or Pop	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tingling/Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dislocation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain During Activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Limited Motion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain While Sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

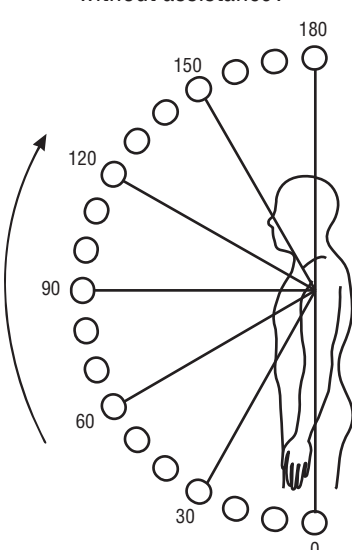
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Has this injury hindered your ability to resume desired activities?  No  Yes

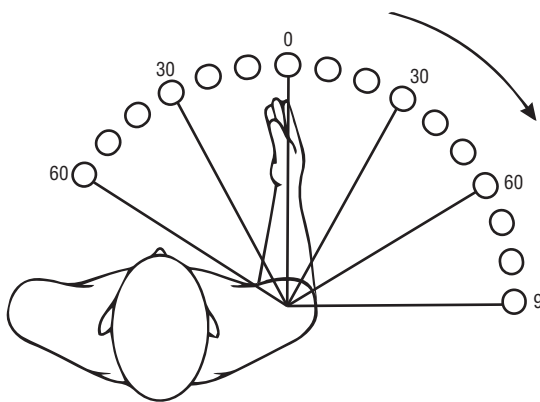
Describe: \_\_\_\_\_

**IDENTIFYING THE PAIN**

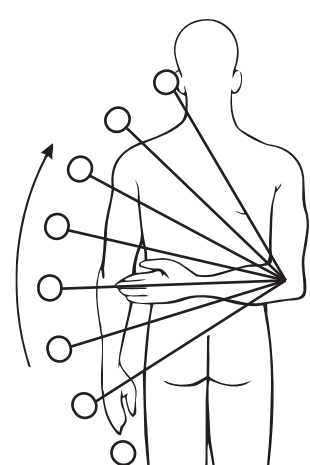
How high can you raise your arm without assistance?



With your elbow at your side, how far outward will your forearm go?



How far inward and upward behind your back can you reach?



**ALLEVIATING FACTORS**

<input type="checkbox"/> Nothing Helps	<input type="checkbox"/> Ice
<input type="checkbox"/> Rest	<input type="checkbox"/> Elevation
<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching
<input type="checkbox"/> PT/OT	<input type="checkbox"/> NSAIDs
<input type="checkbox"/> Orthotics	<input type="checkbox"/> Brace
<input type="checkbox"/> Previous Surgery	<input type="checkbox"/> Sling
<input type="checkbox"/> Limited Weightbearing	<input type="checkbox"/> Chiropractic Care
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Epidural Steroid Injection
<input type="checkbox"/> Over-the-counter Medication	<input type="checkbox"/> Cortisone Injection
<input type="checkbox"/> Viscosupplementation Injection	
<input type="checkbox"/> Other: _____	

**AGGRAVATING FACTORS**

<input type="checkbox"/> Cannot Identify	<input type="checkbox"/> Lifting
<input type="checkbox"/> Carrying	<input type="checkbox"/> Twisting
<input type="checkbox"/> Pushing/Pulling	<input type="checkbox"/> Gripping
<input type="checkbox"/> Grasping	<input type="checkbox"/> Squeezing
<input type="checkbox"/> Throwing	<input type="checkbox"/> Range of Motion
<input type="checkbox"/> Weightbearing	<input type="checkbox"/> Exercise
<input type="checkbox"/> Previous Surgery	<input type="checkbox"/> Computer Use
<input type="checkbox"/> Changing Clothes	<input type="checkbox"/> Morning
<input type="checkbox"/> Daytime	<input type="checkbox"/> Nighttime
<input type="checkbox"/> Cold Weather	<input type="checkbox"/> Damp Weather
<input type="checkbox"/> Driving	<input type="checkbox"/> Other: _____