

Today's Date: _____

Physician Name: _____

Referring M.D.: _____

Name: _____ Age: _____

Occupation: _____

Dominant hand: Right ___ Left ___

Which shoulder are you being seen for today? Right _____ Left _____ Both _____

Describe problem and injury (if any) & date of onset: _____

Have you experienced prior problems with this shoulder? Yes ___ No ___

Describe: _____

Pain Scale (circle one):

1 2 3 4 5 6 7 8 9 10
Least moderate severe

Pain Quality:

Sharp Dull Throbbing
 Aching Burning

Do you have pain at night? Yes ___ No ___

Weakness in affected arm? Yes ___ No ___

Pain w/ overhead activities? Yes ___ No ___

Do you experience catching w/ certain maneuvers? Yes ___ No ___

Numbness in hand / fingers? Yes ___ No ___

Treatments you have tried for this problem:

Physical Therapy? Yes ___ No ___

Injections/Cortisone? Yes ___ No ___

Surgery? Yes ___ No ___

Medications you have tried for this problem:

Physician Signature: _____ Date: _____

SHOULDER