Shoulder

Was this an injury or did it occur over time? _________________

Date of injury or How long you have had this problem: _________________________

Where do you have the problem? ____

If an injury, describe how it occurred: ____

Have you had this problem before? Yes / No

If so, how was it treated? ____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull
Constant burning		Come and go	Pins & Needles
Explosive	Unrelenting	Throbbing	Electric
Constant	Intermittent	Chronic	
Getting better	Getting worse	Unchanged	
Worse in morning	Worse in evening	Worse at night	

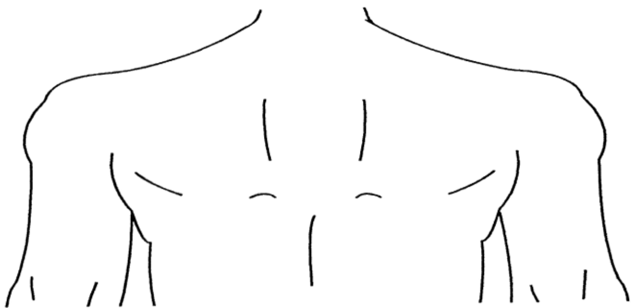
What makes your pain **worse**? ____

What makes your pain **better**? ____

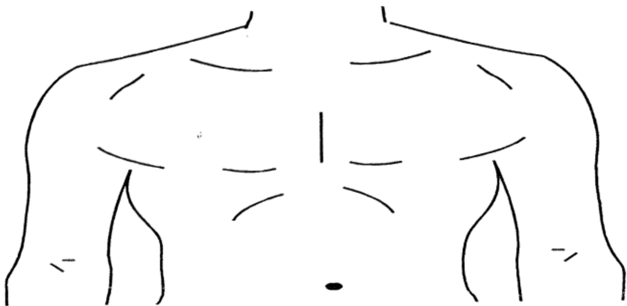
Medications used for this problem: ____

Have you had any tests for this problem: MRI / Bone Scan / X-Ray / Arthrogram / Other: ______________________

Please indicate the location of your pain with an X:



Rear view



Front view

Name____ Date: _____________________________

Do you have numbness or tingling? Yes / No Where? ______________________________

Do you have swelling? Yes / No Where? ______________________________

Have you had instability or disclocations? Yes / No

Do you have popping / catching / grinding ?

Do you have neck pain? Yes / No

Have you had any shoulder surgery? Yes / No

Do you have any other problems not previously described? Yes / No
Please describe: ______________________________
____

Referring Physician: ______________________________

Other Physician you have seen for this problem: ______________________________
____

Dates of work/school missed for this problem: ______________________________

Is there an attorney involved with this problem? If yes, please provide additional information.

____
____
____

Patient Name:______________________________

Patient Signature:______________________________ Date: ____________