

Northtowns Orthopedics, P.C.

SHOULDER HISTORY

Name: _____

Date: _____

Which shoulder bothers you? _____ Right

_____ Left

Which is your dominant hand? _____ Right

_____ Left

How long have you had symptoms? _____

This problem started _____ Suddenly

_____ Gradually

My problem is _____ Constant

_____ Intermittent

How did the problem start?

_____ Work

_____ Sports

_____ Car Accident

_____ Fall

_____ Overuse

_____ Lifting

_____ Pushing

_____ Pulling

_____ Carrying Other _____

My Complaints are: (Check all that apply)

_____ Pain

_____ Swelling _____ Stiffness

_____ Locking

_____ Catching _____ Grinding

Other _____

_____ Lost Motion

_____ Unstable _____ Numbness/Tingling

If pain, the location is: _____

I have difficulty with: (check all that apply)

_____ Moving arm

_____ Sleeping

_____ Throwing

_____ Coughing

_____ Sneezing

_____ Breathing

_____ Lifting

_____ Carrying

_____ Dressing

_____ Washing

Other _____

What makes the problem better:

_____ Rest

_____ Movement

_____ Medication

_____ Ice

_____ Heat

Other _____

Activity level: (check the one best description)

_____ Disabled

_____ Sedentary

_____ Household work

_____ Light work

_____ Medium Work

_____ Vigorous Work

_____ Light Sports

_____ Vigorous Sports

If your normal shoulder performs at 100%, how does your injured shoulder perform? _____%

Reviewed By: _____