

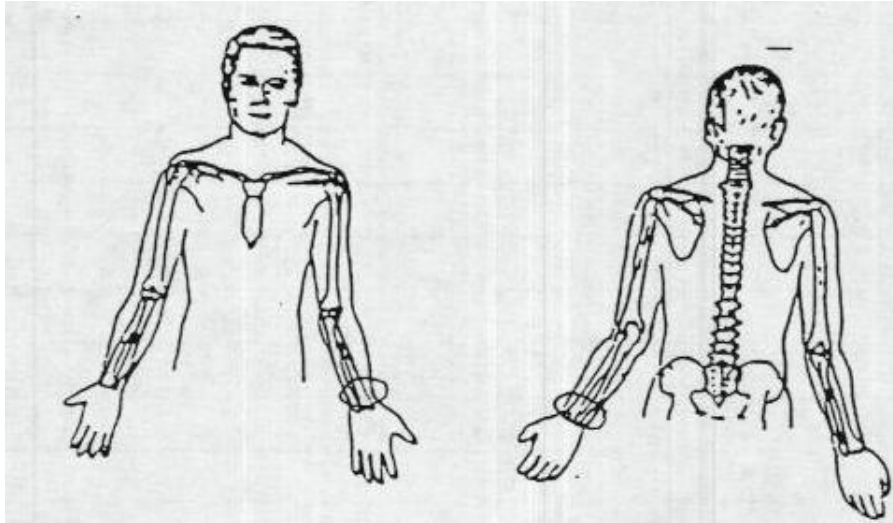
**TOWN CENTER ORTHOPAEDIC ASSOCIATES, P.C.
NEW SHOULDER PROBLEM**

PATIENT NAME: _____ **DATE:** _____

Patient Self Evaluation

Are you having pain in your shoulder? (circle answer)	Yes	No
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Mark where your pain is



Do you have pain in your shoulder at night?	Yes	No
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Do you take pain medication (aspirin, Advil, Tylenol, etc.)?	Yes	No
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Do you take narcotic pain medication (codeine or stronger)?	Yes	No
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On the average, how many pills do you take each day?		
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How bad is your pain today (circle)?

0 1 2 3 4 5 6 7 8 9 10

No pain at all Pain as bad as it can be

How bad is your pain on average (circle)?

0 1 2 3 4 5 6 7 8 9 10

No pain at all Pain as bad as it can be

Does your shoulder feel unstable (as if it is going to dislocate?)	Yes	No
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How unstable is your shoulder (circle)?

0 1 2 3 4 5 6 7 8 9 10

Very Stable Very Unstable

PLEASE TURN OVER AND COMPLETE →

Circle the number in the box that indicates your ability to do the following activities:

0 = Unable to do 1 = Very difficult to do 2 = Somewhat difficult 3 = Not difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work - List	0 1 2 3	0 1 2 3
10. Do usual sport - List	0 1 2 3	0 1 2 3

How bad is your pain?

None = 0 Mild = 1 Moderate = 2 Severe = 3

1. During sports	0 1 2 3
2. Non-sports overhead reaching	0 1 2 3
3. Activities of daily living	0 1 2 3
4. Sitting at rest	0 1 2 3
5. Sleeping	0 1 2 3