



Patient's ID sticker will go here

Return Shoulder Patient Questionnaire

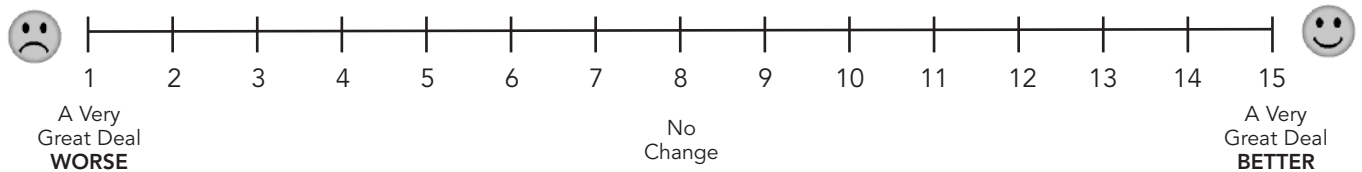
What treatments have you tried for your shoulder **since your last clinic visit**?

- | | | |
|---|--|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Activity modifications | <input type="checkbox"/> Narcotic pain medications | <input type="checkbox"/> Other (list) _____ |
| <input type="checkbox"/> NSAIDs (ibuprofen, naproxen, etc.) | <input type="checkbox"/> Physical therapy | _____ |
| <input type="checkbox"/> Oral steroid | <input type="checkbox"/> Cortisone injection | _____ |

FUNCTION

1. **Since your last clinic visit**, has there been any change in the **FUNCTION** of your treated shoulder?

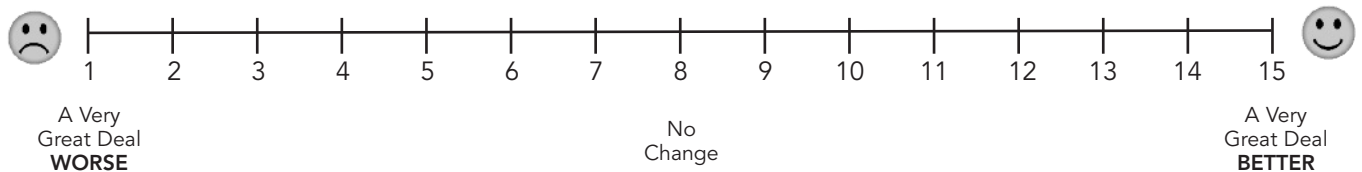
Circle one answer.



PAIN

2. **Since your last clinic visit**, has there been any change in the **PAIN** of your treated shoulder?

Circle one answer.



3. **Since your last clinic visit**, please rate your **RESPONSE** to treatment.

Choose one answer.

- None—no good at all, ineffective treatment
- Poor—some effect but unsatisfactory
- Good—satisfactory effect with occasional episodes of pain or stiffness
- Excellent—ideal response, virtually pain-free

4. **Have you experienced any of the following?**

Please check boxes that apply to you.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Good general health | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Wound problems:
(redness/swelling/drainage) | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Rash | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Reflux/GERD |
| | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinating problems | <input type="checkbox"/> Heartburn |

COMPREHENSIVE SHOULDER ASSESSMENT

Please rank your shoulder's condition with respect to the following categories.

If only one shoulder is problematic, indicate which shoulder: RIGHT LEFT

If both shoulders are problematic, label each slash ("/") with "R" for right or "L" for left. See example.



Category		Make a single slash ("/") along the line	
Overall Shoulder Assessment	Worse it could possibly be		Normal
Range of Motion	No ROM		Full/Normal ROM
Strength	No strength		Full/Normal Strength
Stability	No stability (easily dislocates, feels "loose")		Normal Stability
Activities of Daily Living (personal hygiene, dressing, sleeping, eating)	Unable to do		Able to perform all ADLs
Sports and Leisure Activities	Unable to do		Able to perform all desired activities
Effect of Shoulder Condition on Mental Well-being	Worse possible distress (anxiety, sadness, stress)		No distress

SHOULDER ASSESSMENT FORM – AMERICAN SHOULDER AND ELBOW SURGEONS

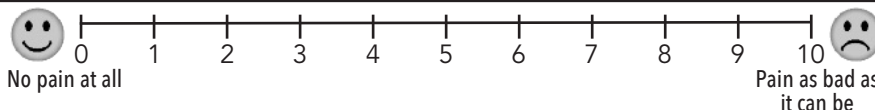
Check the number in the box that indicates your ability to do the following activities:

0 = Unable to do 1 = Very Difficult 2 = Somewhat Difficult 3 = Normal

Activity	LEFT Arm	RIGHT Arm
1. Put on a coat	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
2. Sleep on your painful or affected side	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
3. Wash back/do up bra in back	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4. Manage toileting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5. Comb/Wash hair	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6. Reach a high shelf	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
7. Lift 10 pounds above shoulder	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8. Throw a ball overhand	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
9. Do usual work- List:	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
10. Do usual sport- List:	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

PAIN

On the following scale of 0-10, please **circle** your answer. **How bad is your pain today?**



FUNCTION

On the following scale of 0-10, please **circle** what you consider to be the most current **overall function of your shoulder.**

