TWIN CITIES ORTHOPEDICS
Orthopedic Medicine & Surgery

Name _____

DOB _____

Date_____

Shoulder Form

Age:	Ht:	Wt:	Sex: ☐ Male ☐ Female
Occupation:		Retired ☐	Disabled ☐ Last worked:
Referring Dr:		Primary Dr:	
Right Handed ☐	Left Handed ☐		

Current Problem Details

What problem are you being seen for today?

Is this related to: ☐ Auto Accident ☐ Work Injury
☐ Other Accident ☐ Not Accident related

Date of accident/injury _____

How long have you had symptoms?_____

On set of symptoms: ☐ sudden ☐ gradual

How would you describe your pain? ☐ sharp ☐ dull
☐ thobbing ☐ numb/tingling ☐ locking ☐ clicking/snapping

Is your pain? ☐ getting worse ☐ getting better ☐ staying same

Have you lost range of motion?	Y	N
Is your shoulder weak?	Y	N
Do you have neck pain?	Y	N
Do you have Numbness/tingling in your hands?	Y	N

History of Current Problem

Please describe the history of this problem or how your symptoms started.

Tech Notes Only

Physician Notes Only

Treatment History

Have you seen other health care providers for this problem? Y N If yes, please list_____

What medications have you tried for this? _____

What treatments have you tried?

☐ PHYSICAL THERAPY ☐ CHIROPRACTIC ☐ Surgery _____

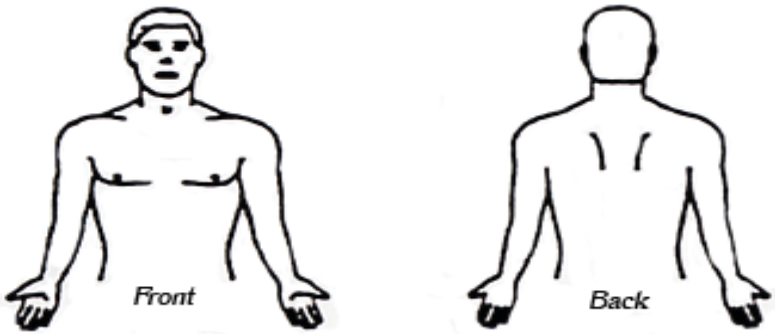
☐ INJECTIONS: (please list date of last one) _____

What tests have you had? (please list where and when)

☐ MRI _____ ☐ X-RAY _____

Patient Self Evaluation

Are you having pain in your shoulder? Y N
Mark where your pain is.



Do you have pain in your shoulder at night? Y N
Do you take non-nartic pain medication? Y N
Circle the meds your taking (tylenol, ibuprofen, aleeve, advil, naproxen)
Do you take narcotic pain meds? Y N
per day_____

How bad is your pain today (mark line)?

0------|------|-----|-----|-----|-----|------|-----|-----|------10
No pain at all Pain as bad as it can be

Does your shoulder feel unstable as if it is going to dislocate? Y N

How unstable is your shoulder (mark line)?

0------|------|-----|-----|-----|-----|------|-----|-----|------10
Very Stable Very Unstable

Circle the number in the box that indicates your ability to do the following activites?
0=unable to do 1=very difficult 2=somewhat difficult 3=not difficult.

Activity	Right arm	Left arm
Put on coat	0 1 2 3	0 1 2 3
Sleep on your affected shoulder	0 1 2 3	0 1 2 3
Wash back / doing bra in back	0 1 2 3	0 1 2 3
Managing toilet	0 1 2 3	0 1 2 3
Comb hair	0 1 2 3	0 1 2 3
Reach a high shelf	0 1 2 3	0 1 2 3
Lift 10 lbs above the shoulder	0 1 2 3	0 1 2 3
Throw a ball overhead	0 1 2 3	0 1 2 3
Do usual work: list	0 1 2 3	0 1 2 3

Last revised 3/6/08