

Orthopaedic Associates of Zanesville

2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

SHOULDER PAIN QUESTIONNAIRE

atient Name:	_ DOB:	Date:				
Which shoulder is bothering you?		Left	Right	Both		
Are you left handed or right handed?		Left	Right			
What type of work do you do?			0			
Did your shoulder pain start with a specific in	iury?		Yes on	r No		
o If "yes": Date of injury:						
Mechanism of injury:						
o Did you feel a pop or a snap with the i		Yes on	r No			
o Is the injury work related?	Is the injury work related?			Yes or No		
o Is it the result of a car accident?			Yes on			
If there was no injury, did the pain start with painting, etc.)? O If "yes", what started the pain?						
If you did not have an injury, when did the pa	in start?					
What are your primary sports and/or activities						
How do you describe your pain?						
How severe is it? (1-10 scale)						
Have you dropped items due to a shoulder cor	Yes or No					
Do any of the following increase your pain?						
Sleeping on the affected shoulder:	Yes	Minin	nally	No		
o Lifting your arm overhead:	Yes			No		
o Reaching out from your side:	Yes	Minimally		No		
o Reaching behind your back:	Yes	Minimally		No		
o Throwing motion:	Yes	Minimally		No		
o Participating in sports:	Yes	Minimally		No		
 Work activities: 	Yes	•		No		
 Is there anything else that increases yo 	ur pain?					
Do any of the following decrease your pain?						
o Rest:	Yes	Minin		No		
o Ice:	Yes			No		
o Heat:	Yes	•		No		
 Over the counter meds (Tylenol/Advil) 		Minimally No				
o Prescription meds:	Yes	Minimally No		No		
o Is there anything else that decreases yo	ur pain?					
Does the pain move down your arm or up into your neck?		Yes or No				
Do you have shoulder pain at night?			Yes or	No		
Do you have any of the following symptoms?						



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SHOULDER PAIN QUESTIONNAIRE (cont'd)

o Clickin	g, popping, or grinding	in your shoulder:	Yes or No		
	ess of your shoulder:	Yes or No Yes or No Yes or No Yes or No			
o Weakn	ess of your arm, elbow				
o Numbr	ess or tingling in your a				
	ss of your shoulder:				
o Persistent or recurrent neck pain:			Yes or No		
o Are the	re any other symptoms	regarding your should	der that we should know abou		
Have you had If "yes" what t	any previous surgery to ype of surgery did you	your shoulder? have and when did yo	Yes or No u have the surgery?		
_					
	any previous treatment	for your shoulder pair	1 such as:		
	ne injections:		Yes or No		
	al Therapy:	Yes or No			
7.7.7	ractic care:	Yes or No			
o Acupui			Yes or No		
o Any ot	her previous treatment f	for your shoulder pain	7		
	any x-rays taken of you Date of x-ray:		or staying about the same? Yes or No		
	X-ray facility:				
Have you had	an MRI of your shoulde	er?	Yes or No		
o If yes:	Date of MRI:				
	MRI facility:				
RRENT MEDICA more than 14 medic	ATIONS (include non-pres cations, please list on a sepa	cription meds and herba trate sheet)	al supplements, etc.		
me of Medication	Dose How Often?	Name of Medication	Dose How Often?		



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ALLERGIES: Medications (Please describe)	None	Yes	
	N	V	
Latex	None	Yes	
Metal	None	Yes	