

SHOULDER QUESTIONNAIRE

NAME: _____ DATE: _____

HOW LONG HAS YOUR SHOULDER HURT? _____

IF A LONG LASTING PROBLEM WHEN DID THIS EPISODE START? _____

HOW DID THIS EPISODE OR PROBLEM START? _____

ARE YOU NOW OR HAVE YOU EVER BEEN OFF WORK FOR THIS CONDITION? Y N

WHAT MAKES YOUR SHOULDER BETTER? _____

DOES YOUR SHOULDER PAIN AFFECT YOUR JOB? Y N

DOES YOUR SHOULDER PAIN RADIATE UP YOUR NECK OR DOWN YOUR ARM? Y N

DO YOU HAVE NUMBNESS IN YOUR ARM OR HAND? Y N EXPLAIN IF YES _____

DOES YOUR SHOULDER HURT AROUND THE SHOULDER BLADE? Y N

DOES YOUR SHOULDER HURT WITH MOVEMENTS OF THE NECK? Y N EXPLAIN IF YES _____

DO YOU WORK WITH YOUR HANDS ABOVE YOUR HEAD? Y N

DO YOU HAVE A JOB THAT IS REPETITIVE IN NATURE? Y N EXPLAIN IF YES _____

ARE YOU TAKING MEDICATIONS? Y N

IF SO PLEASE LIST THEM AND INCLUDE OVER THE COUNTER MEDICATIONS: _____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? Y N

PLEASE LIST DOCTORS: _____

WHAT TREATMENTS HAVE BEEN DONE AND DID THEY HELP?

_____ Y N

_____ Y N

_____ Y N

PLEASE LIST ANY OTHER INFORMATION THAT COULD HELP US TO HELP YOU: _____
