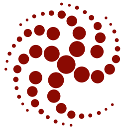


THE CENTER
ORTHOPEDIC & NEUROSURGICAL
CARE & RESEARCH

ORTHO SHOULDER

For Office Use Only: Provider #_______________
MRN #_______________ Staff Initials ___________

Appointment Date: ______/______/______ Name: ____

Date of Birth: ______/______/______ Age: ___________ Dominant Hand: ❑ Right ❑ Left PCP:_______________________

Who referred you toay? ❑ Self ❑ Friend ❑ Provider:____

PLEASE CHECK YES OR NO IF YOU ARE FREQUENTLY BOTHERED BY, OR HAVE BEEN TREATED BY A DOCTOR FOR:

Bleed Easily	Yes ❑ No ❑	Difficulty with Anesthesia	Yes ❑ No ❑	Osteoporosis	Yes ❑ No ❑
Blood Clots	Yes ❑ No ❑	Surgical Complications	Yes ❑ No ❑	History of Infection	Yes ❑ No ❑
Taking Blood Thinners	Yes ❑ No ❑	Numbness/Tingling Extremities	Yes ❑ No ❑	Allergic to Metal	Yes ❑ No ❑

Reason you are seeing the doctor today: ____

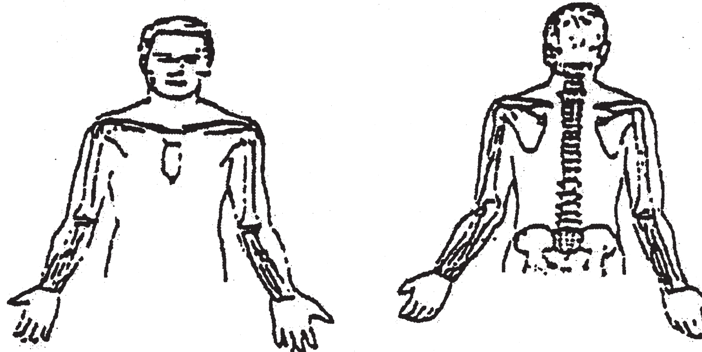
____

Date of Injury: _______________________. Where did your injury occur? ❑ Work ❑ Sports ❑ Motor Vehicle Accident ❑ Other

How did your injury occur? ____

Does your neck hurt? ❑ Yes ❑ No Is your neck stiff? ❑ Yes ❑ No Other joint pain? ______________________________

Are you having **pain in your shoulder**? If yes, indicate the area of **pain** on the diagrams below.



How bad is your pain today? (Circle number)

Least 1 2 3 4 5 6 7 8 9 10 Worst

❑ Sharp ❑ Dull ❑ Pain at night Does your shoulder feel unstable (as if it is going to dislocate)? ❑ Yes ❑ No

Today, how would you rate the instability of your affected shoulder as a percentage of normal (0% to 100%, with 100% being normal)? _______________

Today, how would you rate the instability of your opposite side of your shoulder as a percentage of normal (0% to 100%, with 100% being normal)? _______________

PLEASE COMPLETE BACK OF FORM

FOR EACH ACTIVITY LISTED BELOW, CIRCLE THE NUMBER THAT INDICATES YOUR ABILITY TO PERFORM THE ACTIVITIES

0 = Unable to perform **1 = Very difficult** **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 affected side	0	1	2	3	0	1	2	3
3. Wash back / clasp 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 pounds above shoulders	0	1	2	3	0	1	2	3
8. Throw a ball overhead	0	1	2	3	0	1	2	3
9. Do usual work (List this work below)	0	1	2	3	0	1	2	3

TREATMENT HISTORY

Have you tried any of the following to treat your shoulder?		Did it help?	Comments
Ice	Yes ❏ No ❏	Yes ❏ No ❏	
Heat	Yes ❏ No ❏	Yes ❏ No ❏	
Exercise	Yes ❏ No ❏	Yes ❏ No ❏	
Rest	Yes ❏ No ❏	Yes ❏ No ❏	
Physical Therapy	Yes ❏ No ❏	Yes ❏ No ❏	
Medication	Yes ❏ No ❏	Yes ❏ No ❏	
Previous Injections	Yes ❏ No ❏	Yes ❏ No ❏	
Surgery	Yes ❏ No ❏	Yes ❏ No ❏	

If you had surgery, what procedure and by whom? ____

____