

SHOULDER SURVEY

Name: _____ Date: ____/____/____ Date of Birth: ____/____/____
Last First MI

Gender: Male Female Dominant Hand: Right Left Problem Shoulder: Right Left Job Injury: Yes No

Occupation: _____ Date last worked: ____/____/____ Legal Claim: Yes No

How bad is your pain today?

0 1 2 3 4 5 6 7 8 9 10
 No pain at all Worst pain imaginable

Which word below best describes your pain?

None Moderate
 Mild Severe

Please select the statement that best describes your shoulder:

I have no pain
 I have slight pain during activity
 I have increased pain during activities
 I have moderate/severe pain with activity
 I have severe pain and need medication

	Yes	No		0=unable to do 2=somewhat difficult	1=very difficult to do 3=not difficult		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is your shoulder comfortable with your arm at rest by your side?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your shoulder allow you to sleep comfortably?			Right arm	Left arm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you reach the small of your back to tuck in your shirt?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you place your hand behind your head with the elbow straight out to the side?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you lift 8 lbs. (a full gallon container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you carry 20 lbs. at your side with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you toss a ball underhand 10 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you throw a ball overhand 20 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can you wash the back of your opposite shoulder with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would your shoulder allow you to work full time at your usual job?			0 1 2 3	0 1 2 3

Please select the ONE statement that best describes your injured shoulder's function.

- Normal function. I can do all activities of daily living, work and sports activities that I did before my injury (lifting 30 or more pounds, throwing, tennis, swimming).
- I have mild limitations in sports and work. I can throw but limited, can lift 15-20 pounds, able to wash back, comb hair and get dressed.
- I have moderate limitations in overhead work, sports and lifting (10 pounds). Unable to throw or serve in tennis. Have difficulty with washing back, combing hair or getting dressed (need help sometimes).
- I have severe limitations. Cannot do usual work or lifting. No sports. Need help washing and dressing. Can feed myself and comb hair.
- Complete disability of arm.

Please rate how your shoulder problem affects your ability to work.

4 Fully able to work
 3
 2
 1
 0 Unable to work

Please rate how your shoulder problem affects your ability to participate in sports or recreational activities.

4 Fully able to participate
 3
 2
 1
 0 Unable to participate

Please choose the highest level you are able to use your hands to perform tasks:

- Can use hands only at waist level
- Can use hands at chest level
- Can use hands at neck level
- Can use hands to the top of my head
- Can use hands at levels over my head

CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling anxious or depressed)?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all Quite a bit
- A little bit Extremely
- Moderately

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

On a scale of 100 with 0 being the worst and 100 being the best, overall, how does your shoulder feel currently? _____

--	--	--

Demographic Information

Race: White Black Hispanic Asian Other _____

Marital Status: Single Married Divorced/Separated Widowed

Education: 8th grade High School Associates Bachelors Graduate

Other _____

Do you drink alcohol? Yes No

If yes, how many drinks per week? 1-6 7-12 13-18 >18

Do/did you smoke Yes No

If yes, how many packs per day? _____

How long have/had you smoked? _____

When was the last time you smoked? _____

Do you have diabetes? Type I Type II No

Does/has anyone in your immediate family have/had the same shoulder problem? Yes No

If so, what is their relationship (parent, sibling, child, etc)? _____

Contact Information

Home Phone Number: _____

Day Phone Number: _____ Ext. _____

Alternate Phone Number: _____ Ext. _____

Mobile Phone Number: _____

E-Mail _____

Permanent Address:

Street _____

City _____ State _____ Zip _____