Shoulder Patient Intake Form

Account # _____ Date: _____

Name: _____ **Preferred Name:** _____ **Age:** ____ **Hand Dominance: R / L** **DOB:** _____

Primary Care Physician: _____

Affected side: R / L or Both **Location:** _____ **Symptom:** Pain Numbness Decreased Motion Weak

When did this occur? _____

Did the injury occur at work? Y / N **If so, is it worker's comp?** Y / N **Do you have an attorney?** Y / N

How did this occur ? Fall Assault Surgery Lifting Pulling Reaching Repetitive Throwing Overuse

Shoveling Other: _____

Would you describe the pain as: Mild Moderate Severe

How would you describe the pain? Burning Aching Sharp Shooting Electric Stabbing Throbbing Deep

When is it painful? Continuous At night With activity At rest Other: _____

Where is the primary pain located? Front Top Back Upper arm Side of shoulder Collarbone Underarm

Shoulder blade Neck Other: _____

On a scale of 0 to 10 how would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? Daily activities Exercise Lifting objects Lifting away from body Sudden movements

Therapy Reaching behind Reaching overhead Reaching across Sports

Sleeping on the affected side Nothing Other: _____

What makes the pain better? Heat Ice Injection NSAIDs Pain medications Rest Exercise Physical Therapy

Have you seen another physician for this problem? Y / N **If so, who?** _____

Have you had any tests for this problem? Xrays MRI CT Scan Nerve studies

If so, when? _____ **Where?** _____

Have you ever had an injection for this problem? Y / N **If so, when?** _____ **Did it help?** Y / N

Have you ever had surgery on the affected area? Y / N **If so, when?** _____ **Who was the surgeon?** _____

What is your occupation? _____

Do Not Fill Out

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Name: _____

Acct #: _____

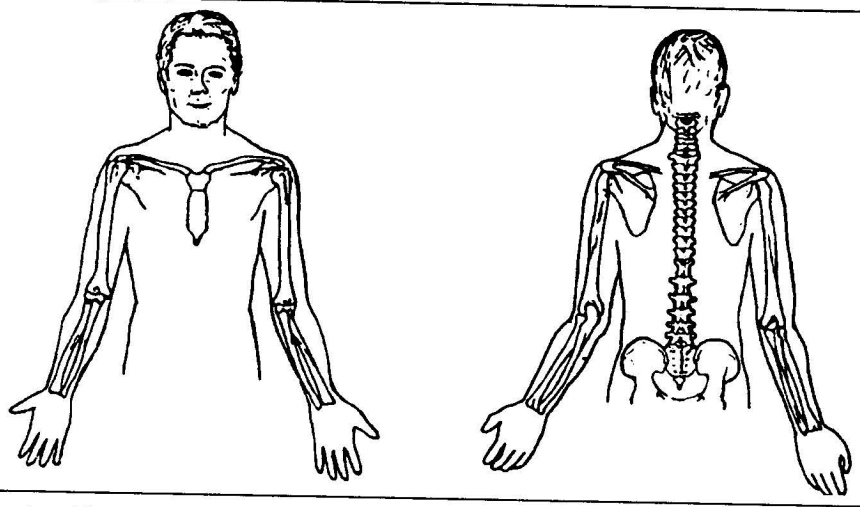
Date: _____

KNOXVILLE ORTHOPAEDIC CLINIC
Shoulder Evaluation Intake

PATIENT SHOULDER EVALUATION

Are you having pain in your shoulder? (circle correct answer)	Yes	No

Mark where your pain is on this diagram:



Do you have pain in your shoulder at night?	Yes	No
Do you take pain medication (aspirin, Advil, Tylenol etc.)?	Yes	No
Do you take narcotic pain medication (codeine or stronger)?	Yes	No
How many pills do you take each day (average)?	pills	

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?)	Yes	No

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 activities

0 = **Unable** to do; 1 = **Very** difficult to do; 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 or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toiletting	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 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work - List:	0 1 2 3	0 1 2 3
10. Do usual sport - List:	0 1 2 3	0 1 2 3