Ortho Nebraska

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Omaha, NE 68144
phone: (402) 609-3000
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Shoulder Questionnaire - Page 1

Appointment Date: ____________________ Date of Birth: ____________________

ID:	Patient Name:	OrthoNebraska Physician:	Referring Physician:	Receptionist:
		Kirk S. Hutton, M.D.		

Problem Shoulder: O Right O Left O Both

Hand Dominance: O Right-Handed O Left Handed O Ambidextrous

Primary Sport: ____________________ Position: ____________________ Years Played: ____________________

Injury & Treatment History

What is the primary reason for seeking medical attention (please choose one):

O Loss of Shoulder Function O Pain O Stiffness O Shoulder Coming Out O Weakness O Other ____________

Date of Onset of Symptoms: ____________________ Did you have an injury at the onset of symptoms? O Yes O No

If yes, was it work related? O Yes O No Sport related? O Yes O No

Describe how the injury occurred: ____

____

____

Please rate these activities based on the following scale:

0 = unable to do 1 = very difficult to do

2 = somewhat difficult 3 = not difficult

	Right Arm	Left Arm
1. Putting on a coat	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
2. Sleeping on your painful or affected side	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
3. Washing back/doing up your bra on your back	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
4. Managing the toilet	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
5. Combing your hair	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
6. Reaching a high shelf	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
7. Lifting 10 lbs. above your shoulder	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
8. Throwing a ball overhand	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
9. Doing usual work, list	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3
10. Doing usual sport, list:	O 0 O 1 O 2 O 3	O 0 O 1 O 2 O 3

Have you seen anyone else for treatment of this problem? (ER, family physician, chiro, specialist, other)

Family Physician: ____________________ Specialist: ____________________

Has your shoulder been injected? O Yes O No If yes, # __________ by whom __________

Thirty minutes after the injection, how much improvement did you have?

O Worse O 0-25% O 26-50% O 51-75% O 76-100%

What was the long term effect?

O Worse O 0-25% O 26-50% O 51-75% O 76-100%

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Shoulder Questionnaire - Page 2

Appointment Date: ____________________

ID:	Patient Name:	OrthoNebraska Physician:	Referring Physician:	Receptionist:
		Kirk S. Hutton, M.D.		

Have you had previous shoulder surgery? O Yes O No

Operation: ______________________ Date: ______________

Operation: ______________________ Date: ______________

Have you had supervised physical therapy? O Yes O No

Did you try other modalities, such as: O Ultrasound O TENS O ElecStim O Other:

Pain Evaluation

Do you have pain in your shoulder now? O Yes O No

Do you take pain medication? (aspirin, Advil, Tylenol, etc.) O Yes O No

Do you take narcotic pain medication (codeine or stronger) O Yes O No

How many pills do you take each day? (average) ____________

How bad is your pain today? (0=none, 10=severe) ____________

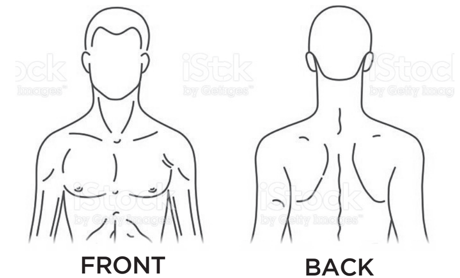
Do you have a loss of motion? O Yes O No

Do you notice popping or catching when moving the shoulder? O Yes O No

Do you notice numbness or pain going down into the fingers? O Yes O No

Do you have pain in your shoulder? O Yes O No

Please circle the area you are having pain on the picture below.



Shoulder Instability

Have you ever had a shoulder dislocation that someone else had to put back in? O Yes O No

If yes, how many times? ____________________

How often does your shoulder feel like it will go out? O Never O Rarely O Occasionally O Frequently

Answer the following only if your shoulder dislocated out of the socket:

Does this instability occur with: O Sport O Daily Living O Sleep

Which direction does it go back in: O Front O Back O Bottom O All O Unknown

How does your shoulder go back in: O By itself O I pull on it O Someone else assists

How is your shoulder instability changing with time? O Improving O Unchanged O Getting worse

How does your shoulder instability affect your ability to compete in sports?

O No problems during competition
O I have instability, but can continue to compete.
O I rarely have to stop competing.
O I occasionally have to stop competing.
O I frequently have instability and have to stop.
O I cannot compete due to instability.

Does certain position of your arm interfere with your performance?

O No O Yes, with my arm above my head O Yes, with my arm in front of my body

Patient Signature: ____

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