

## Shoulder Pain Questionnaire

Name \_\_\_\_\_

Which shoulder is bothering you?                      Left                      Right                      Both

Are you left handed or right handed?                      Left                      Right

What type of work do you do? \_\_\_\_\_

Did your shoulder pain start with a specific injury?                      Yes                      No

If yes:                      Date of injury: \_\_\_\_\_

Mechanism of injury: \_\_\_\_\_

Did you feel a pop or snap with the injury:                      Yes                      No

Is the injury work related:                      Yes                      No

If there was no injury, did the pain start with a particular activity (such as baseball, tennis, painting, etc.)?                      Yes                      No

If yes, what started the pain? \_\_\_\_\_

If you did not have an injury, when did the pain start? \_\_\_\_\_

What are your primary sports and/or activities? \_\_\_\_\_

How would you describe your pain? \_\_\_\_\_

Do any of the following increase your pain?

Sleeping on affected shoulder:                      Yes                      Minimally                      No

Lifting your arm overhead:                      Yes                      Minimally                      No

Reaching out from your side:                      Yes                      Minimally                      No

Reaching behind your back:                      Yes                      Minimally                      No

Throwing motion:                      Yes                      Minimally                      No

Participating in sports:                      Yes                      Minimally                      No

Work activities:                      Yes                      Minimally                      No

Is there anything else that increases your pain: \_\_\_\_\_

Do any of the following decrease your pain?

Rest:                      Yes                      Minimally                      No

Ice:                      Yes                      Minimally                      No

Heat:                      Yes                      Minimally                      No

Over the counter medicines (Tylenol/Advil)                      Yes                      Minimally                      No

Prescription medications:                      Yes                      Minimally                      No

Is there anything else that decreases your pain: \_\_\_\_\_  
\_\_\_\_\_

Does the pain move down your arm or up to your neck? Yes No

Do you have shoulder pain at night? Yes No

Do you have any of the following symptoms?

Clicking, popping, or grinding in your shoulder: Yes No

Weakness of your shoulder: Yes No

Weakness of your arm, elbow, or hand: Yes No

Numbness or tingling in your arm or hand: Yes No

Stiffness of your shoulder: Yes No

Persistent or recurrent neck pain: Yes No

Are there any other symptoms regarding your shoulder that we should know about?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any previous surgery to your shoulder? Yes No

If yes, what type of surgery did you have and when did you have the surgery?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any previous treatment for your shoulder pain such as:

Cortisone injections: Yes No

Physical therapy: Yes No

Chiropractic care: Yes No

Acupuncture: Yes No

Any other previous treatment for your shoulder pain: \_\_\_\_\_  
\_\_\_\_\_

In general are your symptoms getting better, getting worse, or staying about the same?  
\_\_\_\_\_

Have you had any x-rays taken of your shoulder? Yes No

If yes: Date of x-ray: \_\_\_\_\_

X-ray facility: \_\_\_\_\_

Have you had an MRI of your shoulder? Yes No

If yes: Date of MRI: \_\_\_\_\_

MRI facility: \_\_\_\_\_